STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			GREAT LAKES DR		
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was	for a Recertification and	F00	000	This Plan of Correction is		
	State Licensui	re Survey. This visit			submitted under the State and		
	included the Ir	•			Federal Regulations and Statu	ies	
		•			applicable to long-term care		
	Complaint IN0	U 117U33.			providers. This Plan of Correc		
					does not constitute an admiss		
	Complaint				on part of the facility. We requ		
	IN00117033-S	Substantiated.			this Plan of Correction serve a	S	
	Federal/state	deficiencies related to			our credible allegation of		
	the allegations	s are cited at F166.			compliance. Should you have questions, please feel free to	any	
					cntact me at (219)		
	Survey dates:	October 15, 16, 17,			322-3555.Sincerely,Margaret		
	18, 19, 22, & 2				Moore Executive Director		
	10, 19, 22, & 2	23, 2012					
		202122					
	Facility number						
	Provider numb						
	AIM number:	100266720					
	Survey team:						
	Lara Richards	. R.N., T.C.					
	Heather Tuttle						
		y" Vargas, R.N.					
	Nathleen Kitty	y vargas, K.N.					
	Company of the self-transfer						
	Census bed ty	- T					
	SNF/NF: 136						
	Total: 136						
	Census payor	type:					
	Medicare: 36	••					
	Medicaid: 77						
	Other: 23						
	Total: 136						
	These deficier	ncies reflect state					
							<u> </u>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

PC5M11

Facility ID:

000123

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/23/2012		
KINDREI	ROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DY	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION		
	findings cited in accordance with 410 IAC 16.2.					
	Quality review completed on October 29, 2012 by Bev Faulkner, RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PC5M11

Facility ID: 000123

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155218	B. WING			10/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-DY	ER	DYER, I	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0164 SS=A	OF RECORDS The resident has privacy and confipersonal and clin Personal privacy medical treatment communications, meetings of family this does not required this section, the refuse the release records to any incommunication. The resident's rigpersonal and clin when the resident health care instituted information contains records, regardle methods, except	the right to personal dentiality of his or her ical records. includes accommodations, it, written and telephone personal care, visits, and y and resident groups, but uire the facility to provide a					
	resident.	ayment contract; or the	F016	6.1	4 The 40 media registerate visio		11/22/2012
	the facility faile privacy was pro- for 1 of 1 male West Unit. This the potential to	ervation and interview, and to ensure that covided while toileting shower rooms on the s deficient practice had a affect 12 males a unit. (West Unit)	TVI(υ +	1.The 12 male residents using the West unit shower room has the potential to be affected. 2.A privacy curtain has been installed in the West unit show room. 3.Education has been completed with the housekeep supervisor and staff on Privacy Confidentiality.	d n ver ping	11/22/2012

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Event ID: PC5M11

Facility ID: 000123

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings includ	le:			4.The ED/Designee will audi		
					shower rooms for maintenance		
	The Environme	ental Tour was			shower curtains once a week f	-	
	conducted on 10/19/12 at 1:35 p.m.,				one month, then twice a month for one month, then once a mo		
		enance Supervisor, the			for four months. The results of		
	Maintenance A	•			the audit will be presented in		
		Supervisor and the			monthly PI meeting and the PI		
	Environmental	•			committee will determine if 100		
		Consultant.			compliance has been achieved		
	The mon's sho	wer room on the West			needed monitoring is required.		
		ved. There was no					
		around the toilet.					
		il with hooks attached					
	_	round the toilet, but no					
		was attached to the					
	hooks.						
	Interview with t	he Housekeeping					
	Supervisor at t	he time, indicated the					
	privacy curtain	around the toilet was					
	missing. She ir	ndicated she did not					
	_	orivacy curtain was not					
		rail. She indicated there					
		vacy curtain in use.					
		,					
	3.1-3(p)(4)						
	-·· •(P/('/						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PC5M11

Facility ID: 000123

If continuation sheet Page 4 of 128

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
		155218	A. BUII B. WIN			10/23/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			REAT LAKES DR		
KINIDDEL	TDANGITIONAL (CARE AND REHABILITATION-DYE	-D		IN 46311		
KINDKEL	TRANSITIONAL	CARE AND REHABILITATION-DTE	-11	DIEK,	111 403 1 1		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0166	483.10(f)(2)						
SS=D		MPT EFFORTS TO					
	RESOLVE GRIE						
		e right to prompt efforts by live grievances the resident					
		ing those with respect to					
	the behavior of ot						
		ervation, record review	F01	66	1.Resident B and her family		11/22/2012
		the facility failed to	101		have been notified of the		11, 22, 2012
		ces related to a			discovery of her personal		
	-	chair and missing			wheelchair and her family has		
	_	_			decided they no longer want the		
		promptly resolved for 2			wheelchair and have requeste	d	
	•	s reviewed. (Residents			the facility to dispose of the		
	#B and #C)				wheelchair. Resident C has be reimbursed for missing shirts.	en	
					2. Any resident with a complai	nt	
	Findings includ	le:			or grievance has the potential		
					be affected. All complaints and		
	1. On 10/17/12	2 at 8:25 a.m.,			grievances have been audited		
	Resident #B wa	as observed in the			resolution and documentation	-	
	Main Dining Ro	oom seated in her			the past 90 days and on going		
	wheelchair. He				follow up conducted if		
		e foot pedal. Her left			necessary.3. Education of all department heads, licensed		
		•			nurses and the ED has been		
	•	propel herself and her			completed on		
	•	esting on the half lap			Complaints/Grievances with		
	tray.				emphasis on notification of		
					progress on resolution of the		
		Resident #B was			complaint/grievance within 3 d	-	
	reviewed on 10	0/17/12 at 2:11 p.m.			of the initial complaint/grievand		
	The resident's	diagnoses included,			documentation in the resident		
	but was not lim	ited to, hemiplegia			medical record, and on-going follow up to validate resolution		
	(weakness to o	one side of the body).			and that the resident/family		
	•	•			member are satisfied with the		
	The Annual Mir	nimum Data Set (MDS)			resolution.4. The ED/Designed	9	
		ompleted 8/7/12,			will review the		
	indicated the re				complaints/grievances log to		
					ensure resolution at least once		
	supervision and	d set up help for			week and document on the for	m	

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Event ID: PC5M11

Facility ID: 000123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED	
		155218	B. WIN			10/23/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	locomotion on	and off the unit.			weekly follow up as an ongoin		
					practice of this facility. The dat		
	Interview with	Restorative CNA #1 on			from the complaints/grievance logs will be tracked monthly to		
	10/23/12 at 12	:50 p.m., indicated			determine compliance with 3 c		
	about a month	ago, there were issues			follow up and continued on-go	-	
		nt's wheelchair and the			follow up weekly until resolution		
		ative CNA took the			met with resident/family memb		
		elchair and replaced it			and reported to the Performan	ce	
		wheelchair. The CNA			Improvement Committee in Monthly PI meetings.		
	was not aware				i worthly Fi meetings.		
		onal wheelchair.					
	Teolaento pero	orial Wilcolonali.					
	Interview with	CNA #3 on 10/23/12 at					
		cated the resident's					
	•						
		s replaced due to the					
		tioning, it was making it					
		sident to propel herself					
	in the hallway						
		NA took the resident's					
		d replaced it with a new					
		A's were afraid the					
		oing to throw herself					
		elchair due to the					
	struggle she w	as having propelling.					
	Interview with	Social Service Staff					
		10/19/12 at 1:25 p.m.,					
		she was not aware of					
		s filed on the resident's					
	behalf for the p	วสอน บ เทบเนเอ.					
	Interview with:	Social Service Staff					
		10/23/12 at 3:04 p.m.,					
		she interviewed Social					
		Member #1 who					
	Jervice Staff IV	VICTURE! # I WITH	1				

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Event ID: PC5M11

Facility ID: 000123

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155218	A. BUI B. WIN			10/23/	2012
NAME OF F	DOLUDED OD GUDDU IEI				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIEF	(2300 GI	REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-DY	ΈR	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE I
		she was aware the a concern about the					
	,	onal wheelchair being					
	missing, but sh	_					
	_	ntinued interview at the					
	time, indicated						
	-	rty was not notified					
		rid of the resident's					
	personal whee	lchair.					
		rview with Social					
		Member #2 and LPN #6					
	•	idicated the resident's					
		s broken and she was					
		vheelchair. They					
		esident's wheelchair					
	issuing her a n	yay due to the facility					
	_	esident's responsible					
		notified prior to the					
	•	ng thrown away due to					
		aware the resident's					
	_	he wheelchair. LPN #6					
	indicated the re	esident's personal					
	wheelchair had	d been missing since					
	approximately						
		LPN #6 at 4:00 p.m.,					
		esident's old wheelchair					
		d in the storage garage					
	and the family	would be notified.					
	2 Interview w	ith Resident #C's wife					
		2:30 p.m., indicated					
		as admitted to the					
		12. Further interview at					

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Event ID: PC5M11

Facility ID: 000123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155218	B. WIN			10/23/2	012
			J. 1711		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the time, indica	ated during his first					
	week at the fac	cility, the resident had					
	two shirts miss	sing. The resident's					
		that she reported this to					
		vas told to go and buy					
		and that she would be					
		owever, she had not					
	received a che	-					
	i received a cile	CR.					
	Davious of the	Complaint and					
	Review of the	•					
	_	on 10/17/12 at 1:59					
	' '	on 9/18/12 the					
		filed a grievance					
	related to 2 mis	ssing shirts.					
	Documentation	n indicated the					
	resident's wife	was reimbursed for					
	\$25.73 and the	e grievance was					
	resolved on 9/2	•					
	Interview with	the resident's wife on					
	10/19/12 at 2:4	10 p.m., indicated that					
	she had not re	ceived her					
	reimbursemen	t for the two shirts. She					
	indicated that s	she hates to keep					
		is afraid she will not					
	_	mbursement before her					
		charged next week.					
	Tidobalia is als	onargod nozi wook.					
	Interview with	Social Service Staff					
		10/19/12 at 2:45 p.m.,					
		esident's wife was					
		uy 2 new shirts and the					
	I -	eimburse her. She					
	indicated the p	revious Administrator					
	had signed off	on the grievance prior					

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155218	B. WI			10/23/	2012
NAME OF I	PROVIDER OR SUPPLIER	•	_	STREET A	DDRESS, CITY, STATE, ZIP CODE	_	
TWINE OF F	NO VIDER OR BUILDEN	·		2300 GF	REAT LAKES DR		
KINDREI	D TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER, I	N 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s wife receiving a					
		as not aware if the					
		nistrator processed the					
	request for rein						
	•	timely manner. The					
		indicated the resident's					
		ot received her check					
	1	waiting for the check to					
		porate. She indicated if					
		reimbursed from petty					
		d have, but company					
		s that any type of					
		t must come from					
	corporate.						
	Review of the f	acility					
		evance policy on					
	•	0 p.m., which was					
		e Regional Interim					
		sing #2 and identified					
		cated the following:					
	as current, mai	cated the following.					
	-"Acknowledge	and document the					
	complaint/griev						
		orm to the Executive					
	Director"						
		propriate Department					
	Head to investi						
	-"investigate to	•					
	complaint/griev						
	-"notify residen						
	1	ible party of progress					
	within three (3)						
	complaint/griev						
	-"determine a r						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	E SURVEY LETED 3/2012		
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DYI	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR YER DYER, IN 46311					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
TAG	This Federal tag relates to Complaint IN00117033. 3.1-7(a)(2)	TAG	DEFICIENCY)		DATE		

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	H DDIG	00	COMPL	ETED
		155218		ILDING		10/23/	2012
		.002.0	B. WIN				
NAME OF F	PROVIDER OR SUPPLIE	R		STREET A	DDRESS, CITY, STATE, ZIP CODE		
1112112 01 1	NO VIDEN ON DOLLER	•		2300 GF	REAT LAKES DR		
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-DY	′ER	DYER, I	N 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
_		· · · · · · · · · · · · · · · · · · ·		IAU			DATE
F0225	483.13(c)(1)(ii)-(i						ļ
SS=D	INVESTIGATE/F						
	ALLEGATIONS/						
		not employ individuals who					
		I guilty of abusing,					
		streating residents by a					
		ave had a finding entered					
		rse aide registry concerning					
		mistreatment of residents or					
		of their property; and report					
		t has of actions by a court of					
	•	mployee, which would					
		s for service as a nurse aide					
		taff to the State nurse aide					
	registry or licens	ing authorities.					
	The facility must	ensure that all alleged					
	•	ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property					
	are reported imm						
		the facility and to other					
		dance with State law					
		ned procedures (including to					
	•	and certification agency).					
	line otate survey	and certification agency).					
	The facility must	have evidence that all					
	alleged violations						
	•	d must prevent further					
	_	while the investigation is in					
	progress.	e a.e eeagaaee					
	p g						
	The results of all	investigations must be					
		dministrator or his					
	•	esentative and to other					
		dance with State law					
		State survey and					
		ncy) within 5 working days of					
		if the alleged violation is					
		ate corrective action must					
	be taken.						
	Based on reco	ord review and	F02	$_{225}$	1.Residebt #61 reported to h	ner	11/22/2012
1			1 - 7-				

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Event ID: PC5M11

Facility ID: 000123

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		155218		LDING		10/23/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINIDDEI	TPANSITIONAL (CARE AND REHABILITATION-DY	ED		IN 46311		
				,	111 40311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	·		DATE
		acility failed to ensure			daughter and ISDH that on 10/14/2012 after she had bee	n	
		verbal abuse was			assisted to the floor while		
	immediately re	•			transferring from the shower of	hair	
	Administrator f	or 1 of 3 allegations of			with the C.N.A., the C.N.A. ye		
	abuse reviewe	d. (Resident #61)			at her. Resident #61's Daught		
					reported the concern to the U		
	Findings includ	de:			Manager on 10/16/2012. The	unit	
					manager failed to identify the concern as an allegation of at	NICO.	
	Interview with	Resident #61 on			and report to the ED. ISDH	use	
	10/16/12 at 1:5	54 p.m., indicated that			surveyors notified the facility [ONS	
	CNA #4 had ye	•			on 10/17/2012 about the alleg		
	_	ng when she fell in the			abuse. The Facility Administra	ation	
	-	The resident indicated			interviewed the resident and h		
					daughter together on 10/17/20		
		ot help her enough to			at 1730. Residnet #61 stated		
		ne shower chair to the			the C.N.A. had yelled when the nurse and C.N.A. were	е	
		d her leg gave out and			transferring her to the Wheeld	hair	
		esident indicated the			from the floor and she lifted he		
		her for not helping with			right leg. Resident #61 stated	she	
		he resident and her			did not believe there was any		
	daughter indica	ated they reported this			intent of harm but she could n	0	
	to the East Uni	it Manager on			longer stand on her right leg during the transfer. Pain		
	10/16/12.				assessment completed with n	0	
					findings. MD and daughter we		
	Interview with	the East Unit Manager			notified of fall and care plan		
	on 10/17/12 at	4:10 p.m., indicated			updated for 2 C.N.A.s with		
		h the resident's			transfers in the shower. The		
		0/16/12 related to care			Nurse was interviewed and st		
		the previous evening.			resident was anxious to get of		
		ne resident and the			the floor and when she and th C.N.A were transferring the	C	
		ghter did not want CNA			resident she lifted up her right	lea	
	1				and all her weight shifted to he	-	
	_	ne resident anymore.			left leg, that's the time when the		
		ted the resident was			C.N.A said for the resident to		
		floor in the shower			stand on both feet. The reside	ent	
	_	before and there was			was assisted to bed with the		
	some indication	n the CNA had raised			nurse and C.N.A. and the nur	se	

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/23/2012		
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DYE	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR YER DYER, IN 46311				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	her voice at the resident. He indicated that he had not reported this to the Administrator or the Director of Nursing. Interview with the Director of Nursing on 10/17/12 at 4:20 p.m., indicated that she was not aware of the allegation of verbal abuse involving Resident #61. She also indicated the East Unit Manager should have reported this immediately to the Administrator when the resident's daughter voiced these concerns on 10/16/12. 3.1-28(c)		completed another head to too assessment without findings. 2. The C.N.A. has not worker since 10/15/2012. The C.N.A. been terminated. The Unit Manager was suspended on 10/17/2012 and will be educated on Abuse and reporting abuse Residents that could complete resident interview were interviewed on 10/17/2012 for other allegations of abuse. An resident that was not interviewable had a family interview conducted. Any finding were immediately reported to ED for follow up. 3. In-servicing and education started on 10/17/2012 with all staff on Abuse, Responding to and investigating allegations of abuse at 17:45PM and will continue on all shifts until all stare in-serviced. 4. The DNS / Designee will complete interviews with 60 residents or families quarterly an ongoing practice of this fact to identify allegations of abuse and compliance with reporting and follow up. All findings will reported in Monthly PI meeting all findings. The SDC/Designe will in-service on Abuse policy and procedures with orientation and as needed.	d has ded 2. All 3. any y ngs the of taff as iility 3. be g for se		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REAT LAKES DR		
	TRANSITIONAL (CARE AND REHABILITATION-DY	ER_		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPLN ETC POLICIES The facility must of written policies armistreatment, negresidents and misproperty. Based on reconsinterview, the facility abust related to immediallegation of verification of verification abuse reviewed. Findings including Interview with Fi	acility failed to ensure see policy was followed ediately reporting an erbal abuse to the or 1 of 3 allegations of d. (Resident #61) e: Resident #61 on 4 p.m., indicated that	F02	TAG 26	1.Residebt #61 reported to he daughter and ISDH that on 10/14/2012 after she had been assisted to the floor while transferring from the shower of with the C.N.A., the C.N.A. ye at her. Resident #61's Daught reported the concern to the Un Manager on 10/16/2012. The manager failed to identify the concern as an allegation of about and report to the ED. ISDH surveyors notified the facility I on 10/17/2012 about the alleg abuse. The Facility Administratinterviewed the resident and he daughter together on 10/17/20 at 1730. Residnet #61 stated the C.N.A. had yelled when the nurse and C.N.A. were transferring her to the Wheeled from the floor and she lifted he right leg. Resident #61 stated	hair elled er nit unit uuse DNS ed ation per D12 that e	11/22/2012
	•	ner for not helping with			did not believe there was any		
		he resident and her			intent of harm but she could n longer stand on her right leg	U	
	-	ated they reported this			during the transfer. Pain		
	to the East Uni	t Manager on			assessment completed with n	0	
	10/16/12.				findings. MD and daughter we		
					notified of fall and care plan		
	Interview with t	he East Unit Manager			updated for 2 C.N.A.s with		
	on 10/17/12 at	4:10 p.m., indicated			transfers in the shower. The Nurse was interviewed and sta	atod	
	that he met with	h the resident's			resident was anxious to get of		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED	
		155218	B. WIN			10/23/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-DY	FR		IN 46311		
			LIV		114 +0011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LISC IDENTIFYING INFORMATION)		TAG		DATE	
	•	0/16/12 related to care			the floor and when she and the C.N.A were transferring the	9	
	concerns from the previous evening.				resident she lifted up her right	len	
	He indicated th	ne resident and the			and all her weight shifted to he		
	resident's dauເ	ghter did not want CNA			left leg, that's the time when th		
	#4 caring for th	ne resident anymore.			C.N.A said for the resident to		
	He also indicat	ted the resident was			stand on both feet. The reside	nt	
	lowered to the	floor in the shower			was assisted to bed with the		
		before and there was			nurse and C.N.A. and the nurs		
		n the CNA had raised			completed another head to toe assessment without findings.	;	
	her voice at the				2.The C.N.A. has not worked	, l	
		ne had not reported this			since 10/15/2012. The C.N.A		
		trator or the Director of			been terminated. The Unit		
		trator or the Director or			Manager was suspended on		
	Nursing.				10/17/2012 and will be educate		
					on Abuse and reporting abuse		
		the Director of Nursing			Residents that could complete resident interview were	a	
		4:20 p.m., indicated			interviewed on 10/17/2012 for	anv	
		ot aware of the			other allegations of abuse. Any	-	
	allegation of ve	erbal abuse involving			resident that was not	,	
	Resident #61.	She also indicated the			interviewable had a family		
	East Unit Mana	ager should have			interview conducted. Any findir	~	
	reported this in	nmediately to the			were immediately reported to t	the	
	Administrator v	when the resident's			ED for follow up. 3.In-servicing and education		
	daughter voice	ed these concerns on			started on 10/17/2012 with all		
	10/16/12.				staff on Abuse, Responding to		
					and investigating allegations o		
	The facility Abo	use policy was			abuse at 17:45PM and will		
		0/17/12 at 3:00 p.m.			continue on all shifts until all st	taff	
		s provided by the			are in-serviced.		
		sing and identified as			4.The DNS / Designee will complete interviews with 60		
		•			residents or families quarterly	as	
		buse policy indicated			an ongoing practice of this fac		
		"the center staff must			to identify allegations of abuse		
		ed violations involving			and compliance with reporting		
		neglect, or abuse,			and follow up. All findings will I		
		es of unknown source			reported in Monthly PI meeting		
	and misapprop	oriation of resident			all findings. The SDC/Designe	e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:			00	(X3) DATE COMPL	
	155218	A. BUI B. WIN	ILDING NG		10/23/	
NAME OF B	NDOVIDED OD GUIDN IED	D. WII		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			REAT LAKES DR		
KINDREI	D TRANSITIONAL CARE AND REHABILITATION-DYI	ER	DYER,	IN 46311		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	property and are reported			will in-service on Abuse policy	,	
	immediately to the administrator of			and procedures with orientation	on	
	the facility and to other officials in			and as needed.		
	accordance with State law through					
	established procedures (including to					
	the State survey and certification agency)."					
	agency).					
	3.1-28(a)					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155218	B. WING			10/23/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DYE	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	483.15(a) DIGNITY AND RI INDIVIDUALITY						
	The facility must promote care for residents in a manner and in an environment that						
		ances each resident's ct in full recognition of his y.					
		rvation, record review	F02	41	1.Resident #32 now has an		11/22/2012
	and interview,	the facility failed to			indwelling Catheter bag cover.		
	ensure staff kn	ocked on the door prior			The C.N.A has been in-service		
	to entering the	resident's room as well			on Dignity related to knocking doors before entering the roon		
	as explaining to	o the resident what			and asking permission to move		
		going to provide. This			clothing or blankets.		
	•	residents who met the			2.All residents with an		
	criteria for dign	ity. The facility also			indwelling catheter have the		
		e a dignity bag was in			potential to be affected. An aud		
		esidents reviewed for			of all residents with an indwelli catheter was completed and a		
		y (urinary) catheters.			catheter bags have a cover in	"	
	(Residents #32				place. All residents have the		
	(11031001113 #02				potential to be affected related	to	
	Findings includ	le:			staff knocking on the door beforentering and moving clothes obedding without asking		
	1. On 10/16/12	2 at 10:26 a.m., CNA			permission.		
		sident #180's room.			3.All staff have been in-servi	ced	
		ot knock prior to			on Quality of Life with emphas		
		sident's room. The			on covering catheter bags and	I	
		eeded to walk over to			treating the resident's private space and property with respe	oct	
	-	resident's bed and pull			by knocking on doors before	Ci	
		wn, exposing the			entering the room and asking		
		s. The CNA did not			permission to move or inspect		
					personal clothes or bedding.		
		esident what he was			4.The DNS/Designee will	بامما	
	going to do.				interview 6 residents once a w for compliance with knocking of		
	Th	D :			the door before entering and	// ·	
		Resident #180 was			asking permission before		
	reviewed on 10	0/18/12 at 8:33 a.m.			removing clothes or bedding for	or 3	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155218	B. WIN			10/23/	2012
NAME OF T	DOLUDED OF GURNING			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>t</u>		2300 G	REAT LAKES DR		
		CARE AND REHABILITATION-D	/ER		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		an	DATE
		diagnoses included,			months. The DNS/Designee was audit resident's indwelling	/111	
		nited to, traumatic			catheters for dignity bag		
		d encephalopathy			placement once weekly X 3		
	(brain disorder)).			months, then monthly X 3		
					months. The DNS/Designee w		
	Interview with t	he District Director of			complete observations of staff		
	Clinical Operat	ions (DDOC) on			once a week for the next 3	ring	
	10/18/12 at 9:0	0 a.m., indicated even			months on each unit for knock on doors and asking permission	-	
	though the resi	dent was			to remove clothes or bedding.		
	non-responsive	e, the CNA still should			The results of these audits wil		
	have knocked	on the door prior to			tracked and reported to the PI		
		sident's room and			committee monthly for 6 mont	hs	
	•	m what he was going			or until 100% compliance is	o DI	
	to do.	3 3			achieved as determined by the committee.	# F1	
					committee.		
	2. Resident #3	2 was observed on					
	10/16/12 at 10:	:10 a.m. He was					
		oom in a wheelchair.					
		ad a Foley catheter (a					
		nto the resident's					
		n urine) in place. The					
		e bag, attached to the					
		was hanging on the					
	_	0 0					
		elchair. The urine in the					
	•	vas visible. The					
	urainage bag w	vas not in a dignity bag.					
	The resident w	as observed on					
		:18 a.m. The resident's					
		ge bag was hanging f the wheelchair. The					
		vas not in a dignity bag					
		ave a cover on it.					
		e in the drainage bag					
	that was visible	<u>)</u> .					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155218	B. WIN			10/23/20	112
CE OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER	C		2300 GI	REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-DY	ÆR	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	The record for reviewed on 10. The resident had included, but wourinary obstruct. The Quarterly I (MDS) assessment re 10/2/12, indicating indwelling cath. Interview with the on 10/22/12 at the resident's ushould have be should have be	Resident #32 was 0/22/12 at 10:38 a.m. ad diagnoses that vere not limited to, stion and lung cancer. Minimum Data Set ment with an ference date of ted the resident had an		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE

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Facility ID: 000123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-DYI	ĒR		IN 46311		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0242 SS=D	483.15(b) SELF-DETERMIN MAKE CHOICES The resident has activities, schedul consistent with his assessments, and with members of and outside the fa about aspects of that are significant Based on recor interview, the fa 1 of 3 residents of the 6 who may choices were of between male a related to show Findings includ Interview with F 10/16/12 at 8:2 he had not had week. He indicate he had not had week. He indicate sign a paper th The record for reviewed on 10 The resident's a Data Set (MDS 9/26/12, indicate important to the	the right to choose les, and health care s or her interests, d plans of care; interact the community both inside acility; and make choices his or her life in the facility at to the resident. The review and acility failed to ensure as reviewed for choices et the criteria for a choice and female caregivers wers. (Resident #10) The resident #10 on the series and that the refuses, es not want the "young thim a shower. He dight the resident made thim the shower in over a character of the refuses, the shower in the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower. He dight that the refuse is not want the "young thim a shower is not want t	F02		1. Resident #10 has had his request for male staff to provide his shower accommodated as allows or offer his shower whe male C.N.A.s are on the schedes of he may have his preference accommodated. 2. All residents with a prefence on the gender the staff providing their showed have the potential to be affected. All residents have been interviewed for bathing choices and their plan of care updated reflect their choices. 3. Educat has been completed with all Department heads, licensed nurses, and C.N.As on Quality Life with emphasis on resident choices for bathing. 4. The DNS/Designee will review resident's choices for bathing admission /readmission, Quarterly, annually and PRN to ensure choices are reasonably accommodated. This will be an ongoing practice of this facility Residents/family members will interviewed quarterly for bathing choices and the results tracked and reported to the PI committed in monthly PI meeting for	n dule es s of r ed. s to ion o / n 60 be ng d	11/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		<u> </u>		IAG	compliance.		DATE
		e bath. The MDS also			Compliance.		
	indicated the resident needed limited assist of one person for personal hygiene.						
	The plan of ca	re, dated 9/28/12, for					
	self care perfo	rmance deficit,					
	indicated the re	esident's strength was					
	that he was ab	le to verbally express					
	needs and his	• •					
	preferences w	ere to be honored					
	whenever pos						
	Whenever poss	SIDIC.					
	Review of the	shower schedule on					
		26 p.m., indicated the					
		•					
		receive his shower on					
	i vvednesday ar	nd Saturday evenings.					
	The sheet see sh						
		neet, dated 10/6/12,					
		esident refused his					
	shower and do	ocumentation indicated					
	the Social Wor	ker also tried to					
	encourage him	n. There was no					
	documented re	eason for the refusal.					
	The shower sh	neet, dated 10/13/12,					
		esident again refused					
	his shower.	coldent again relaced					
	This shower.						
	Interview with	the East Unit Manager					
		_					
		4:15 p.m., indicated					
		as very private and took					
		f, he assumed this was					
	the reason the	resident was refusing					
	his showers. I	He was not aware the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155218	A. BU	MULTIPLE CO JILDING	00	COMP	LETED 3/2012		
	PROVIDER OR SUPPLIER	<u> </u>	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR						
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	CARE AND REHABILITATION-D TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL SELSC IDENTIFYING INFORMATION)	YER	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
mo		t want female CNA's		inc			Ditte		
	3.1-3(u)(3)								

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Event ID: PC5M11

Facility ID: 000123

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
KINIDDEL	TDANCITIONAL C	CARE AND REHABILITATION-DY	ED		REAT LAKES DR IN 46311		
KINDREL	TRANSITIONAL	CARE AND REHABILITATION-DT	ER.	DIEK,	111 403 1 1		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0247	483.15(e)(2)					·	
SS=A	RIGHT TO NOTIC						
	ROOM/ROOMMA						
		e right to receive notice					
		nt's room or roommate in					
	the facility is char	_					
	Based on recor		F02	47	1.Resident # 34 was offered	_	11/22/2012
	interview, the fa	acility failed to ensure			room change related to the fac	ility	
	2 of 2 residents	who met the criteria			failing to notify her of a room		
	for Admission,	Transfer, and			change. Resident # 18 was	to	
	-	e given notice prior to			offered a room change related		
	•	and receiving a			the facility failing to notify him the new roommate. Both	JI .	
		•			residents are satisfied with the	ir	
	roommate. (Re	esidents #18 and #34)			rooms.	"	
					2.All residents with a room		
	Findings includ	e:			change or new roommate have	9	
					the potential to be affected. Ar		
	1. Interview wi	th Resident #34 on			resident in need of a room	•	
	10/15/12 at 2·4	7 p.m., indicated that			transfer or receiving a new		
		noved to a different			roommate will be notified in		
					advance and offered the		
		ility within the past 9			opportunity to tour the room pr		
		esident indicated her			to a room move. Residents wil	l be	
	belongings wer	e moved while she			introduced prior to the room		
	was at dialysis.				move. All room to room transfe	ers	
					will be documented and maintained in the medical reco	ard	
	The record for	Resident #34 was			of the resident.	n u	
		0/19/12 at 2:02 p.m.			3. Education on Room-to-Roo	m	
		Nursing progress			Transfers has been completed		
	•	0. 0			with all department heads and		
		0/2/12 at 12:29 p.m.,			Licensed nurses.		
		esident returned from			4. The ED/Designee along with	า	
	•	s transferred to Room			the SSD will sign the form for		
	108-1.				validation that the center		
					discussed the transfer with the	;	
	Interview with S	Social Service Staff			resident, family and/or	_	
		10/19/12 at 2:15 p.m.,			responsible party in advance of		
		was no documentation			the room transfer. The form wi		
					also be completed for validation		
	to indicate if the	e resident had been	1		that residents are introduced p	rior	

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Event ID: PC5M11

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If continuation sheet Page 23 of 128

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	S.			REAT LAKES DR		
KINDRF	TRANSITIONAL (CARE AND REHABILITATION-DYI	-R		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		oom change prior to			to a room move and signed by		
10/2/12.					the SSD and ED/Designee prior		
					to any transfers. This will be an ongoing practice of this facility		
	2. Interview wi	th Resident #18 on			The Ed/Designee will complete		
	10/16/12 at 10	28 a.m., indicated that			once a week interviews with th		
		en notified of getting a			resident or family for verification		
		, she indicated "you			that notification of transfer was		
		en they are coming in."			provided and introduction of ne	ew	
	meet mem will	on they are confing in.			roommates for 4 transfers a		
	The	Decident #40			month x 3 months, then once a		
		Resident #18 was			month for 3 months all findings	5	
		0/19/12 at 2:10 p.m.			will be reported to the PI committee in monthly PI meeti	na	
		in the Nursing			until 100% compliance is	''9	
	progress notes	, indicated the resident			determined by the PI committee	e.	
	had received a	new roommate on					
	12/22/11.						
	Interview with	Social Service Staff					
		the time, indicated					
		ocumentation to					
		esident had been					
	=	receiving her new					
	roommate.						
	3.1-3(v)(2)						
	I		1				

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			P. ,, 11,	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-DY	ER_		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
F0248 SS=D	EACH RES	T INTERESTS/NEEDS OF					
		ies designed to meet, in					
		the comprehensive					
		interests and the physical,					
	mental, and psycl	hosocial well-being of each					
	resident.	-					
	Based on obse	rvation, record review	F02	48	1.Resident #83 now has a ra		11/22/2012
	and interview, t	the facility failed to			with a CD player to play music	c in	
	ensure the resi	dent's preferred			her room and her music		
		ning to music was			preference has been added to	her	
	•	of 1 residents reviewed			plan of care. 2.All residents preferring mu	isic	
	•	vices. (Resident #83)			to be played in their room hav		
	ioi riospice sei	νιου. (πουιαστιί που)			the potential to be affected. Ar		
	Findings includ	e:			audit has been completed of a	ıll	
	Ü				current residents for identification of residents with preference for		
	Resident #83 w	vas observed on			music in their room as an activ		
		45 a.m., 12:40 p.m.			and their plan of care updated	•	
		n. The resident was in			3.Education completed with		
	•	was no music being			department heads, Activity		
	played in the re				department staff, licensed nur		
	p.a.joa iii iiio ic	,o.aoino 100iii.			and C.N.A.s on Activity Progra with emphasis on resident's	สเกร	
	The resident wa	as observed on			preferences and providing		
		9 a.m., 10:29 a.m.,			supplies for activities, and		
	11:20 a.m. and				assistance when needed for the	ne	
		bed and there was no			activity.		
	music in the re				4.The Activity		
	music in the res	SIUCIII S IUUIII.			Director/Designee will monitor residents with preferences for		
	On 10/17/12 at	8·18 a.m. the			activities in the room once we		
		bserved in bed. There			for 3 months, then twice a mo		
					for 3 months to ensure		
		or television on for the			compliance. 60 Residents will		
	resident.				interviewed Quarterly thereaft	er	
					for preferences with in room		
	Continued obse	ervations throughout			activities and supplies to achie		
	the day on 10/1	17/12 at 10·15 a m	1		the activity. All findings will be		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	LDDIC	00	COMPL	ETED
		155218	A. BUI B. WIN	LDING		10/23/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINIDDEI	TDANCITIONAL A	CARE AND REHABILITATION-D	/ED				
KINDKEI	J TRANSITIONAL	CARE AND REHABILITATION-D	IEK	DIEK,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	11:20 a.m., 12	:21 p.m., 2:07 p.m. and			reported to the PI committee		
	3:15 p.m., indi	cated the resident was			monthly in the PI meeting until		
	in bed with the	television on. Various			100% compliance is achieved determined by the PI committee		
	talk shows and	d soap operas were			determined by the r r committee		
		ne television, but no					
		sion shows were on for					
	the resident.						
	and resident.						
	The resident w	vas observed on					
		rious times of the day.					
		vas in bed with the					
		t 8:24 a.m., 9:45 a.m.					
		. There was no music					
	on the television	on.					
	On 10/18/12 a	t 9:45 a.m., the					
	resident's daug	ghter was interviewed.					
		the resident really liked					
		sic and she would					
		sic being provided for					
		the indicated it was one					
		gs the resident could					
	still enjoy.						
	The record for	Resident #83 was					
	reviewed on 10	0/17/12 at 1:13 p.m.					
	The resident h	ad diagnoses that					
	included, but w	vere not limited to,					
	Huntington's c	horea, dysphagia					
	(difficulty swall						
		The resident had been					
	• •	vices since 3/18/12.					
	i on nospice sei	VICES SITIES OF 10/12.					
	The Occasion	Minimum Date Cat					
	1	Minimum Data Set					
	l (MDS) assessi	ment, dated 10/17/12,					

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLET	ΓED
		155218	B. WIN			10/23/20	012
(E. O.E.					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		2300 GI	REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-D	YER	DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	<u> </u>	DATE
		esident's "Preferences					
		Routine and Activities"					
		ng a bed bath, receiving					
		, reading books,					
	• •	or magazines, listening					
		g around animals such					
		articipating in religious					
	activities or pra	actices."					
		care plan, which was					
	not dated, indi						
		one to one program for					
	in room visits a	and stimulation. The					
	resident will be	e visited in her room at					
	the bedside wi	th one on one visits for					
	stimulation and	d interaction with others					
	through next re	eview (strengths: pets,					
	mass, music).						
	The intervention	ons included:					
	Place activity of	calendar in resident					
	room for refere	ence.					
	Activity staff to	visit resident in room					
	at bedside.						
	Activity staff to	offer a variety of					
	,	such as reading to					
	•	ng sensory items,					
	-	for her and showing her					
	pictures.						
	l •	resident to give facial					
		make eye contact and					
	praise all resid	•					
		one o onorto.					
	The Activity Pr	ogress note, dated					
		ited, "The resident					

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PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155218	B. WIN	IG		10/23/	2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDE		24 DE 44 DE 14 DE	,		REAT LAKES DR		
KINDREI) TRANSITIONAL (CARE AND REHABILITATION-DY	'ER	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		o person as when					
		vity staff call her name					
	she will make e	eye contact. Resident's					
	overall condition	on continues to decline					
	physically, due	to her diagnosis.					
	Resident is vis	ited in her room one on					
	one at bedside	. The activity staff and					
	volunteers brin	g soothing music to					
	play for resider	nt. At times she will					
	open her eyes	and appears to listen.					
		able to share her					
	thoughts she d	oes make noises in					
	_	nes. Activity staff also					
	•	otion to help her relax.					
	_	ad to resident from					
	•	evotional books and					
		or the soul with					
	inspirational st						
		ones.					
	Interview with t	the Activity Director on					
		8 a.m., indicated the					
		not have a radio or					
		her room for music.					
		she has never asked					
	, ,	in a radio. She also					
		she had not asked					
	, ,	e of music the resident					
		ndicated the activity					
		music for the resident					
	_	one on one visits but					
	•	ed the resident with a					
		oom to play music					
		cated the resident					
		room most of the time					
	and is isolated.	<u>. </u>					

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PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155218		LDING	00	COMPL 10/23	ETED
	PROVIDER OR SUPPLIER	CARE AND REHABILITATION-DYE	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	10/19/12 at 9:2 had gone into the 10/15/12 and 1 turned the televalso indicated to one on one action and read to held did not provide	Activity Aide #1 on 14 a.m., indicated she che resident's room on 0/16/12 and had vision on for her. She chat she did perform a civity with the resident r. She indicated she any music for the 1/12 through 10/19/12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-DY	ER	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0278 SS=A	483.20(g) - (j) ASSESSMENT						
		ORDINATION/CERTIFIED must accurately reflect the					
	_	e must conduct or assessment with the cipation of health					
	A registered nurs the assessment is	e must sign and certify that s completed.					
	the assessment r	who completes a portion of must sign and certify the portion of the assessment.					
	who willfully and material and false assessment is su penalty of not mo assessment; or a and knowingly ca certify a material resident assessm	and Medicaid, an individual knowingly certifies a estatement in a resident object to a civil money ore than \$1,000 for each or individual who willfully ouses another individual to and false statement in a ment is subject to a civil or inot more than \$5,000 for t.					
	material and false Based on obse and interview, ensure the Min assessments w completed for reviewed for ho 1 of 2 residents	ervation, record review the facility failed to imum Data Set (MDS)	F02	78	1. Resident #62 and Resident #83 have had a their MDS modified and accurately coded hospice services for resident # and dental services for Reside #83.2. All residents with Hosp services and residents meeting criteria for dental services have the potential to be affected. All audit of all residents with Hosp	I for : 62 nt bice g e	11/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
KINDDE		CADE AND DELIABILITATION DV	-D		REAT LAKES DR IN 46311		
KINDREL	J TRANSITIONAL (CARE AND REHABILITATION-DY	EK	DIEK,	111 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the criteria for	dental services.			services have had their MDS		
	(Residents #62	2 and #83)			reviewed and any modification		
	(,			needed submitted. All resident		
	Findings includ	le:			with the need for dental service		
		ic.			have had their MDS audited a		
	4 Deet 1 1/2	0			any with the need for a modified		
		2 was observed on			MDS to be completed have hat the coding completed and MD		
		4 a.m. The resident			modification submitted.3. The		
	was in a Broda	chair and her mouth			MDS nurses have been		
	was open. The	re was a broken tooth			in-serviced on accurate coding	of	
	on the lower po	ortion of her mouth, the			the MDS for assessments. 4.		
	•	outh were discolored			The MDS Coordinator will aud	it	
	and were in po				completed MDS weekly before	•	
	and were in po	or condition.			transmission for accuracy in		
	The record for	Resident #62 was			coding for 3 months then mont		
					for 3 months. All findings will be	be	
		0/18/12 at 2:08 p.m.			reported in monthly PI for	00	
		ad diagnoses that			compliance and the Pi commit will determine if further auditing		
	included, but w	ere not limited to,			required or if 100% compliance	-	
	dementia, hype	ertension and			has been achieved.	•	
	depression.						
	'						
	There was a N	utritional Assessment,					
		that indicated the					
	-						
		ed pureed food and					
		ed liquids. It also					
	indicated in the	e "Oral Health" section					
	that the resider	nt had "caries and					
	decay."						
	-						
	The form titled	"Patient Nursing					
		t 3," dated 9/11/12,					
		The form indicated the					
		nissing teeth" and					
	"caries/decay."						
	The Significant	: Change Minimum					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155218	B. WIN			10/23/2012	
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	TION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	Е
	Data Set (MDS	S) assessment with an					
	assessment re	ference date of					
	9/26/12, was re	eviewed. It indicated					
	the resident did	d not have obvious or					
	likely cavity or	broken natural teeth.					
	, , , , ,						
	Interview with	MDS Coordinator #2 on					
		12 p.m., indicated the					
		accurately coded.					
	Wibo was not a	accurately coded.					
	2 The record f	for Resident #83 was					
		0/17/12 at 1:13 p.m.					
	Teviewed on Te	5/1//12 dt 1.10 p.m.					
	The resident h	ad diagnoses that					
		vere not limited to,					
	· ·	horea and dementia.					
	1	ad been admitted to					
	hospice service	es on 3/18/12.					
	The form titled	"Physician's					
	Certification fo	r Medicare Hospice					
		3/18/12, and signed					
		e Medical Director was					
	•	dicated the resident had					
		nosis of Huntington's					
		mentia. The form also					
		dent #83 was terminally					
		pectancy of six months					
		rminal illness runs its					
	normal course						
	The form titled	"Physician's					
		•					
		r Medicare Hospice					
		6/16/12, and signed					
	by the Hospice	e Medical Director was					

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155218	B. WIN	G		10/23/2012
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE	
					REAT LAKES DR	
KINDREL) TRANSITIONAL	CARE AND REHABILITATION-D	YER	DYER,	IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
		dicated the resident				
	had a terminal	_				
		horea. It indicated the				
		erminally ill with a life six months or less if				
		ness runs its normal				
	course.	icoo iulio ilo iiuliiai				
	Course.					
	The Quarterly	MDS with an				
	1	reference date of				
		eviewed. It indicated				
		as not receiving				
		es and it did not				
	· •	esident had a condition				
		ease that may result in a				
		of less than 6 months.				
	The Quarterly	MDS with an				
	1	eference date of				
	8/28/12, was re	eviewed. It did not				
	indicate the re	sident had a condition				
	or chronic dise	ease that may result in a				
		of less than 6 months.				
	Interview with	MDS Coordinator #2 on				
	10/17/12 at 2:3	35 p.m., indicated the				
	MDS assessm					
		eference dates of				
	5/29/12 and 8/	·				
		oded related to the				
		expectancy. She also				
	indicated the N	IDS with an				
	assessment re	ference date of				
	5/29/12, was ir	naccurately coded				
	related to the r	esident receiving				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 10/23		
	ROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DY	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	hospice services.					
	3.1-31(d)					

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Event ID: PC5M11

Facility ID: 000123

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			В. WП.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R		1	REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-DY	ΈR		IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	483.20(d), 483.2 DEVELOP COM PLANS A facility must us assessment to d the resident's con The facility must care plan for each measurable obje meet a resident's mental and psyc identified in the con The care plan must that are to be fur the resident's hig mental, and psyc required under § that would other §483.25 but are resident's exercis including the righ §483.10(b)(4). Based on obse and interview, ensure a care	o(k)(1) PREHENSIVE CARE se the results of the evelop, review and revise imprehensive plan of care. develop a comprehensive sh resident that includes retives and timetables to se medical, nursing, and shosocial needs that are comprehensive assessment. set describe the services inished to attain or maintain ghest practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, and to refuse treatment under the facility failed to plan was initiated for 1	F02		Resident #34 now has a caplan for dialysis. Resident #5 had a current care plan for non-pressure skin condition		11/22/2012
		receiving dialysis or 1 of 3 residents of			(bruise). Resident #52 dischar home.2. All residents receiving	-	
	the 8 who met	the criteria for skin			dialysis services and all reside	ents	
	conditions (no	n-pressure related).			with bruises have the potentia	l to	
	(Residents #34	•			be affected. An audit of all		
	Findings include	·			residents receiving dialysis services and bruises or the potential for bruises have had their care plans audited and a		
	1. On 10/16/	12 at 1:42 p.m.,			resident without a current care)	
	Resident #52 v	was observed with			plan has had one initiated for dialysis monitoring and bruise.	e	
	areas of reddis	sh/purple discoloration			and the potential for bruises.3		
	to his left and				Education has been complete		

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	DING	00	COMPLI	ETED
	155218				10/23/2	2012
		b. WIN		ADDRESS CITY STATE ZIP CODE		
ROVIDER OR SUPPLIER	t					
TDANGITIONAL (TARE AND REHABILITATION DV	ED				
TITANOTHONAL	SARE AND REHABILITATION-DT		DILIX,	110 40311		
				PROVIDER'S PLAN OF CORRECTION		(X5)
*				CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	•		DATE
On 10/18/12 at resident was of reddish/purple right hand. At was observed hall. Reddish/pobserved to the right hands. On 10/19/12 at and 1:00 p.m., observed with a top of his left at The record for reviewed on 10 A Physician's condicated the replavix (a medication used clots) an medication used clots) daily. Review of the resident did not 10/19/12 at the resident did	t 8:20 a.m., the bserved with a bruise to the top of his 9:48 a.m., the resident in his wheelchair in the burple bruising was e top of his left and to 7:56 a.m., 8:55 a.m., the resident was again areas of bruising to the nd right hands. Resident #52 was 0/19/12 at 8:45 a.m. Order, dated 9/6/12, esident was to receive cation used to prevent d Lovenox (a ed to prevent blood ed to prevent blood ed the resident did not an related to the uising. the East Unit Manager 2:53 p.m., indicated do not have a care plan		TAG	with all licensed nurses for comprehensive care plans. 4. The DNS/Designee will audit of plans weekly x 3 months for implementation of care plans related to residents receiving dialysis and residents with the potential for bruises or bruises then monthly x 3 months and admission, significant change, and quarterly. All findings will reported in monthly PI meetingand the PI committee we determine at 6 months if further monitoring is required or 100%	with be vill er	DATE
R	ROVIDER OR SUPPLIER TRANSITIONAL OF TRANSITION	IDENTIFICATION NUMBER: 155218 ROVIDER OR SUPPLIER TRANSITIONAL CARE AND REHABILITATION-DY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood	ROVIDER OR SUPPLIER TRANSITIONAL CARE AND REHABILITATION-DYER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood clots) daily. Review of the resident's current plan of care indicated the resident did not have a care plan related to the potential for bruising. Interview with the East Unit Manager on 10/19/12 at 2:53 p.m., indicated the resident did not have a care plan related to the potential for bruising	ROVIDER OR SUPPLIER TRANSITIONAL CARE AND REHABILITATION-DYER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood clots) daily. Review of the resident's current plan of care indicated the resident did not have a care plan related to the potential for bruising. Interview with the East Unit Manager on 10/19/12 at 2:53 p.m., indicated the resident did not have a care plan related to the potential for bruising	ROVIDER OR SUPPLIER TRANSITIONAL CARE AND REHABILITATION-DYER SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) ainly. Review of the resident's current plan of care indicated the resident did not have a care plan related to the potential for bruising. Interview with the East Unit Manager on 10/19/12 at 2:53 p.m., indicated the resident did not have a care plan related to the potential for bruising	IDENTIFICATION NUMBER: 155218 ROUNDER OR SUPPLIER ROUNDER OR SUPPLIER RECORDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 10/18/12 at 8:20 a.m., the resident was observed with a readish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was observed to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood clots) daily. Review of the resident's current plan of care indicated the resident did not have a care plan related to the potential for bruising. IDENTIFICATION NUMBER: NING SUBJECT CONTINUES OF DEFICIENCES. STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311 PROVIDER OR SUPPLIER 2300 GREAT LAKES DR DYER, IN 46311 REPRIENT ACTOR SIRVELLON EXCENSIBILATION PER PREPRIENT ACTOR SIRVELON EXCENSIBLE CONSENSATION PER PREPRIENT ACTOR SIRVELON EXCENSATION PER PREPREPRIENT ACTOR SIRVELON EXCENSATION PER PREPRIENT ACTOR SIRVELON EXCENSATION PER PREPRIENT ACTOR SIRVELON EXCENSATION PER PREPREPRIENT ACTOR SIRVELON EXCENSATION PER PREPREPRIENT ACTOR SIRVELON EXCENSATION PER PREPREPRINT ACTOR SIRVELON EXCENSATION PER PR

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Event ID: PC5M11

Facility ID: 000123

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

-	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		LDING IG	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			2300 G	REAT LAKES DR	E	
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-D	YER	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	reviewed on 10 The resident's but was not lim Review of the Data Set (MDS 8/7/12, indicate receiving dialy Review of the plan, indicated related to mon while receiving Interview with on 10/19/12 at	current 8/7/12 care there was no care plan itoring the resident dialysis. the Director of Nursing 12:47 p.m., indicated care plan to monitor the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DDIC	00	COMPL	ETED
		155218	A. BUII			10/23/	2012
			B. WIN		ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
KINDDEE	TDANIOITIONIAL (NADE AND DELIABILITATION DVE			REAT LAKES DR		
KINDREL	TRANSITIONAL (CARE AND REHABILITATION-DYE	=K	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)						
SS=E		UALIFIED PERSONS/PER					
	CARE PLAN						
		vided or arranged by the					
		ovided by qualified					
		lance with each resident's					
	written plan of car		E02	02	4 5		11/22/2012
		rvation, record review	F02	82	Resident # 52 has been discharged home. Resident	dont	11/22/2012
	· ·	the facility failed to			#53 no longer has a pressure	JEIIL	
	• •	an's orders and/or the			ulcer to the Left buttock.		
	•	ere followed as written			Resident #53 has a pressure		
	related to fall p	revention for 1 of 3			ulcer to the Left foot and		
	residents review	wed for accidents of			measurements are obtained		
	the 11 who me	t the criteria for			weekly and care plan updated		
	accidents, mon	itoring of skin			Resident #211 has an MD ord	-	
	conditions for 1	•			for double portions of protein a		
		in conditions of the 8			every meal.Resident #62 has a MD order to discontinue the	an	
	who met the cr				dycem and alarm in the Broda	1	
					chair. Care plan and C.N.A.		
		n-pressure related),			assignment sheet have been		
	•	s for 2 of 3 residents			updated to reflect the MD orde	ers.	
		itrition of the 6 who			Resident #83 has a care plan	to	
	met the criteria	for nutrition, weekly			offer to get resident up for eac	:h	
	documentation	of pressure areas for			meal and honor resident		
	1 of 3 residents	reviewed for pressure			preferences. The care plan ar		
	ulcers of the 4	who met the criteria for			C.N.A. sheet have been updat to reflect the intervention to ge		
	pressure ulcers	s, and not getting a			resident up for meals if resider		
	resident out of	•			agreeable. Resident #32 has a		
		wed for hospice			care plan for the potential for	-	
		dents #32, #52, #53,			bruises related to anticoagualt	ion	
	•				therapy.2. The center will revi	ew	
	#62, #83, and #	1			residents with weight loss for		
					reccommendations, weights a		
	Findings includ	e:			re-weights, pressure ulcers for	Ī	
					weekly measurements, MD orders for diet and accuracy w	/ith	
	 The record f 	for Resident #52 was			tray cards, fall interventions	TUT	
	reviewed on 10)/19/12 at 8:45 a.m.			implemented, residents out of		
	The nutrition pl	an of care, dated			bed for meals per their		

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155218	B. WING	ING		10/23/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			REAT LAKES DR		
KINIDDEI	TDANGITIONAL A	CARE AND REHABILITATION-DYE			N 46311		
KINDKE	J TRANSITIONAL (CARE AND REHABILITATION-DTE	-11	DIEN, I	11 40311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	9/12/12, indica	ted the resident had			preference, non-pressure		
	the potential fo	or weight fluctuations			monitoring for bruises and car		
	-	etic (water pill) use and			plans for the potential of bruise		
		dentures. One of the			to assess that the written plan care is being implemented in	OI	
	_	ndicated to monitor and			accordance with MD orders ar	hd	
		veight loss, determine			followed through. 3. Education		
	1	_			with all Nursing staff, RDs,		
		st, and follow facility			Dietary manager, Dietary staff	on	
	•	eight loss (complete a			RD recommendations, weights	3	
		ere was a 5 pound			and re-weights, monitoring of		
		n the previous weight			pressure ulcers and non-press		
	and notify the	Registered Dietitian).			skin conditions, Accidents and		
					Supervision with emphasis on		
	Review of the	resident's weight			implementing fall interventions ADL assistance and Care	,	
		ed on 9/7/12, he			plans.4. The DNS/designee w	rill	
	1	ounds and on 9/13/12			meet with the RD weekly in a		
		3.2 pounds. A 14.8			NAR meeting to review all		
	1	•			weights and re-weights and fo	or	
	l •	here was no re-weight			RD recommendations regardir	ng	
	available for re	eview.			implemention weekly as an		
					ongoing practice of this		
	A Physician's o	order, dated 9/6/12,			facility. The RD/Dietary mange		
	indicated the re	esident was receiving a			will complete a weekly tray car		
	regular diet. T	he only "Nutrition			audit for accuracy x 3 months, then monthly for 3 months. The		
	Services Note'	' available for review			DNS/Designee will audit all	ic .	
		2/12, prior to the			pressure and non-pressure ski	in	
	resident's weig				conditions for weekly monitoring		
	Tooldonto worg	Jii 1000.			and care plan implementation		
	Intonious	the East Unit Manager			an on going practice of this		
		the East Unit Manager			facility. The IDT will make rou	nds	
		2:33 p.m., indicated			twice daily to ensure fall		
		usually weighed			interventions are implemented		
	1	a discrepancy was			and sign the C.N.A. sheet with each round and discuss in the		
	noted, the Reg	istered Dietitian (RD)			IDT meeting. Care plans will be		
	was notified ar	nd it was up to her to			reviewed weekly for) C	
	ask for a re-we	•			implementation related to MD		
					orders, fall interventions,		
	Interview with	the RD and Dietary			Pressure and Non-pressure		
	IIIICI VICVV WILLI	the ND and Dietary					

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Event ID: PC5M11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ´				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIT	ILDING	00	COMPL	ETED
		155218	B. WI			10/23/	2012
			2. ,, 11		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Technician on	10/19/12 at 2:45 p.m.,			monitoring x 3 months then		
	indicated they	were not aware of the			monthly, on admission, quarte	•	
	resident's weig	ht loss and would look			and with significant change. A	All	
	into it.				findings will be reviewed in monthly PI meeting for 6 mont	he	
					and the PI commitee will	.113	
	2 The record	for Resident #53 was			determine any required		
)/18/12 at 1:38 p.m.			monitoring needed to achieve		
		•			100% compliance.		
		Admission Nursing					
		ated 8/3/12, indicated					
		as admitted with a					
		ire ulcer to her left					
	buttock that me						
	centimeters (cr	n) x 4.0 cm.					
	Davieus of the N	Maaldy Duagovina I II.a.a.					
		Weekly Pressure Ulcer					
	· •	ed no measurements					
		ock wound were					
	documented or	n 8/10 and 8/17/12.					
	The current pla	an of care, indicated the					
	· ·	pressure ulcer to her					
		and a history of					
	pressure ulcers	<u>-</u>					
	l ·	ndicated to measure					
	•	and depth of the					
	pressure ulcers	o.					
	Interview with t	the District Director of					
		ions on 10/23/12 at					
		cated the resident no					
	_ ·						
		pressure area to the					
		ne further indicated the					
	l ·	to the left buttock					
		een measured weekly.					
	3. On 10/17/12	2 at 9:00 a.m.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155218	B. WIN	G		10/23/2012	
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINDDEL	TDANCITIONAL (CARE AND REHABILITATION-D	/ED		REAT LAKES DR IN 46311		
			ILK		110 403 1 1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5) LETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	ATE
	Resident #211	was observed eating					
		e Main Dining room.					
	The resident w	as served one waffle, a					
	bowl of hot cer	eal, and 2 sausage					
	links. The resi	dent did not receive					
	double portions	s of protein.					
	0 40/1-115						
		t 12:48 p.m., the					
		bserved eating lunch in					
		g room. The resident e cup of ice cream, a					
		g, a regular portion of					
		g, seven green beans,					
	and one biscui						
	On 10/18/12 at	t 8:07 a.m., the					
	resident was o	bserved in the Main					
	Dining room wa	aiting on breakfast. At					
	8:34 a.m., she	was served one					
	serving of scra	mbled eggs, one piece					
		ne bowl of hot cereal.					
		id not receive double					
	portions.						
	The record for	Resident #211 was					
		0/17/12 at 8:28 a.m.					
		vas admitted to the					
		/12 from the hospital.					
	_	diagnoses included,					
		mited to, muscle					
		iculty in walking, atrial					
		n blood pressure and					
	osteoporosis.	•					
	Review of Phys	sician Orders on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	/2012
			S. 11 II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		recap, indicated the					
		o receive double					
	portions of pro	tein at every meal.					
		Dietary progress note,					
	dated 7/26/12,	indicated the					
	recommendati	on by the Registered					
	Dietitian was to	o serve the resident					
	double portion	s of protein at all					
	meals.						
	Interview with	the Dietary Food					
	Manager on 10	0/18/12 at 8:40 a.m.,					
	indicated he w	as not aware the					
	resident was to	o receive double					
	portions of pro	tein at all meals.					
	4. Resident #6	2 was observed on					
	10/17/12 at 8:3	34 a.m. She was					
	seated in a Bro	oda chair. The resident					
	had a self rele	asing seat belt around					
		the buckle in the front					
		vas no pull tab alarm					
	attached to the	•					
	The resident w	vas observed on					
		:30 a.m., she was					
		oda chair in the West					
		om. She had a self					
		n. There was no pull tab					
		to the resident.					
		a to the resident.					
	On 10/17/12 a	t 12:40 p.m., the					
		n the Broda chair in the					
		here was no null tah					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155218	B. WIN			10/23/2	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	alarm attached	I to the resident. There					
	was a self rele	ase seat belt in place.					
	The resident w	as observed on					
	10/17/12 at 3:2	20 p.m., she was					
		Broda chair in front of					
		ation. There was a self					
		elt in place. There was					
		m attached to the					
	resident.	in attached to the					
	resident.						
	On 10/10/10 at	10.15 a m tha					
		t 8:15 a.m., the					
		p in the Broda chair					
		ase seat belt in place.					
	There was no l	pull tab alarm in place.					
		t 1:55 p.m., the					
	resident was o	bserved being					
	transferred froi	m the Broda chair to					
	the bed by CN	A #1 and CNA #2. The					
	self release se	at belt was on the					
	resident. There	e was no Dycem (a					
		vent the resident from					
	•	chair under the resident					
	٥,	no pull tab on the chair					
	attached to the	•					
		, rodiuciii.					
	Interview with	CNA #1 on 10/18/12 at					
	•	cated there was no					
		pull tab alarm on the					
		nued interview with					
	· ·	ated she had not					
		I tab alarm since the					
	seat belt was a	applied.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155218	B. WI			10/23/2012
NAMEOUR	DECEMBED OF GUIDE 122			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2300 GF	REAT LAKES DR	
		CARE AND REHABILITATION-D	YER	<u> </u>	N 46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		e West Unit CNA				
	. •	neet in her pocket. On				
		55 p.m., the CNA				
		eet was reviewed. It				
		esident was to have a				
		mat at the bedside, a				
		It, a pressure alarm to				
		tab to chair, a cushion				
	•	nd a foot buddy to the				
	Broda chair.					
		D : 1 1 1/00				
		Resident #62 was				
		0/18/12 at 2:08 p.m.				
		ad diagnoses that				
	•	vere not limited to,				
		ular degeneration and				
	seizures.					
	There was a P	hysician's Order, dated				
		dicated the resident				
	·	elf-releasing seat belt.				
		•				
		alls Care Plan with a				
	revision date o	,				
		esident was at risk for				
	falls due to uns	• •				
	psychoactive d					
	communication	n/comprehension,				
	disease proces	ss condition, and				
	dementia. The	interventions to be				
	used to preven	t falls were:				
	Broda chair fo	r proper positioning				
	-concave mattr					
	-Dycem to Bro					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A БІП	ILDING	00	COMPLETI	ED
		155218	A. BUI B. WIN			10/23/20	12
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		1	REAT LAKES DR		
KINDRE	O TRANSITIONAL	CARE AND REHABILITATION-D	YER	1	IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		mat next to bed					
	-pressure alarr						
	-pull tab alarm	to wheelchair					
	-self release w	heelchair belt to Broda					
	chair						
	The October 2	012 Physician Order					
		ed the resident was to					
	have a pull tab						
	•	d a wheelchair cushion					
	with Dycem.						
	William Dy Comin						
	The resident h	ad a fall on 10/5/12.					
		"Post Fall Evaluation					
		id not indicate the					
	· ·						
		ne self release belt on					
	at the time of t	ne tail.					
	Interview with	the West Unit Manager					
		_					
		2:15 p.m., indicated					
		d not have a self					
		n, as ordered by the					
		he time of the fall on					
		indicated the resident					
		by a Hospice CNA who					
	did not place tl	he seat belt on the					
	resident. She a	also indicated facility					
	staff did not ap	pply the seat belt after					
	Hospice staff le	eft.					
		(Name of Hospice					
	Company) Hos	spice "Incident Report					
	Tracking Form	," dated 10/5/12, was					
	reviewed. It in	dicated, "Staff at					
		ne) Nursing facility					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	stated that pat	ient fell from Broda					
	chair striking h	er head, resulting in					
	need for emer	gency hospital visit. Our					
		ealth Aide) had gotten					
	,	:15 a.m., did care, and					
		acility, patient was fully					
		• •					
		da and next to the					
		n. The fall occurred at					
		11:00 a.m. The seat					
	belt was not fa	stened/secured and					
	was underneat	th patient."					
	Interview with	the West Unit Manager					
		2:30 p.m., indicated					
		ad Physician's Orders					
		larm and for Dycem in					
	•	indicated the fall					
		not in place as ordered					
	_	ations on 10/17/12 and					
	10/18/12. She	indicated the devices					
	should have be	een in place.					
	5. Resident #8	3 resided on the South					
	Unit. She was	observed on 10/15/12					
	at 10:45 a.m	12:40 p.m. and at 2:30					
		ent was in bed in her					
	room.	5 1745 III 554 III 1161					
	100111.						
	The resident ::	as observed on					
		19 a.m., 10:29 a.m.,					
		d 1:30 p.m. The					
	resident was ir	n bed. At 8:19 a.m., the					
	residents on th	e South Unit were					
	eating breakfas	st in the dining room.					
		3					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	ER			REAT LAKES DR		
KINIDDEI	TDANGITIONAL	CARE AND REHABILITATION-D	/ED		IN 46311		
MINDREL	J TRANSITIONAL	CARE AND REHABILITATION-D	IEN	DIEK,	110 40511		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 10/17/12 a	at 8:18 a.m., 10:15 a.m.,					
	11:20 a.m., 12	2:21 p.m., 2:07 p.m. and					
	3:15 p.m., the	resident was observed					
	· ·	21 p.m., the residents					
		Unit were eating lunch					
	in the dining re	_					
		00111.					
	The regident	was observed on					
		arious times of the day.					
		was in bed at 8:24 a.m.,					
		12:30 p.m. At 8:24					
	a.m.,the resid	ents on the South Unit					
	were eating b	reakfast in the dining					
	room. At 12:	30 p.m., the residents					
	on the South	Unit were eating lunch					
	in the dining re	_					
	On 10/19/12 a	at 8:12 a.m., the					
		he South Unit were in					
	-	m being served					
	breakfast. Res	sident #83 was in bed.					
	The record for	r Resident #83 was					
	reviewed on 1	0/17/12 at 1:13 p.m.					
	The resident h	nad diagnoses that					
	included, but v	were not limited to,					
		chorea, dysphagia					
	(difficulty swal						
	hypertension.						
	i ilaherrension.						
	The Ostaber (2012 Dhysisian Order					
		2012 Physician Order					
	· ·	ed the resident was to					
		ated, not for greater					
	than 2 hours p	per family request.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	ETED
		155218	B. WIN			10/23/2	2012
			D. 112		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Care Plan	that was revised on					
	2/28/12, indica	ted the resident					
	required extens	sive assist with adl's					
	(activities of da	aily living) due to the					
	diagnosis of H	untington's chorea.					
		5					
	Some of the in	terventions were:					
		ist with bed mobility,					
		ing, and hygiene					
	-up for all mea						
	•	t out of bed when she					
	wakes up as so	oon as possible					
		t CNA (Certified					
	_	ant) assignment sheet					
		It indicated the					
	resident was to	be, "up for all meals."					
		progress notes dated					
		gh 10/19/12, indicated					
		vidence that the					
	resident had re	efused to get out of					
	bed.						
	Interview with	the South Unit Manager					
	on 10/19/12 at	8:29 a.m., indicated					
	the resident ha	nd not been up in the					
		d had not been up for					
		2 through 10/18/12.					
		the staff should have					
		dent out of bed as					
	•	e resident's care plan.					
	i iilulcaleu oli lii 	e residents care plan.					
	6 Posidont #2	2 was observed on					
	10/16/2012 at	10:09 a.m. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
		1			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		bruise on the back of					
		1 and 1/2 inches in					
	size.						
	On 10/22/12 a	t 11:17 a.m., the					
	resident was o	bserved in his room					
	seated in the v	vheelchair. There was a					
	fading bruise of	on the back of his right					
	hand. There w	as a bruise on the					
	inside of his le	ft forearm that was a					
	1/2 inch in diar	meter and was purple in					
	color.						
	COIOI.						
	The record for	Resident #32 was					
		0/22/12 at 10:38 a.m.					
		ad diagnoses that					
		vas not limited to, lung					
	cancer.	vas not innited to, lang					
	Caricer.						
	There was a C	Care Plan, dated					
		ndicated the resident					
	· ·						
		abnormal bleeding or					
	-	ue to anticoagulant					
	,	hat reduce the risk of					
	,	e related to Coumadin					
	(a blood thinne	er) therapy.					
	The start of						
	The intervention						
	- medications						
		nd report to nurse any of					
	_	igns and symptoms of					
	bleeding: bleed	ding gums, nose					
	bleeds, unusua	al bruising, tarry/black					
		discolored urine					
	•	gns and symptoms of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUI	LDING	00	COMPLETED
		155218	B. WIN			10/23/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	· ·		2300 GI	REAT LAKES DR	
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	,	sing, ecchymosis,				
	epistaxis)(nose	e bleed)				
	The October 2	012 Physician Order				
	Sheet, indicate	ed the resident was				
	receiving Coun	nadin 8 mg (milligrams)				
	_	y alternating with				
		mg every other day.				
	204111441111110					
	The "Weekly S	skin Check" form				
	_	10/16/12, indicated				
	•					
		non-pressure skin				
	concerns.					
		as discharged to the				
		17/12 at 7:01 a.m. The				
	resident was re	eadmitted to the facility				
	on 10/19/12.					
	The "Skin Insp	ection Anatomy				
	Diagram" form	, dated 10/20/12,				
	indicated the re	esident had no open				
		non-pressure areas.				
	The "Patient N	ursing Evaluation"				
	form, dated 10	•				
	•	the facility, indicated				
		₹ '				
		skin was supple, normal				
	and free from o	open areas.				
	 Interview with	LPN #2 on 10/22/12 at				
	• •	licated when a bruise				
		as to be documented				
		essure Skin Condition"				
	form and it was	s to be monitored				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION		ATE SURVEY	
AND PLAN	OF CORRECTION	155218	A. BUI	LDING	00		MPLETED 23/2012
		100210	B. WIN				Z3/ZU Z
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP (CODE	
KINIDDEI	D TDANCITIONAL	CARE AND REHABILITATION-D	VED		REAT LAKES DR		
)	DIEK,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COL		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
TAG		,		TAG	BETTEIERET		DATE
	,	solved. She also n a resident was					
		admitted to the facility,					
		to do a skin inspection nd was to document the					
	Evaluation" for	e "Patient Nursing					
	Evaluation 101	III.					
	Thoro was no	evidence the bruise on					
		e resident's right hand					
		that was on the					
		forearm was assessed					
		before discharge to					
		nd upon return from the					
		e was no evidence that					
		o "monitor for signs					
	•	of bleeding such as					
		being followed.					
	Didising was	being followed.					
	LPN #2 compl	eted "Weekly					
		Skin Condition					
		e resident on 10/22/12					
		She indicated the					
		bruise on his left					
		as 1.3 cm x 1.2 cm					
		n size and was purple					
	,	Iso indicated the					
		bruise on the back of					
		that was 3 cm x 3.2					
	cm in size.	I that was 5 on A 5.2					
	0111 111 0120.						
	Interview with	LPN #2 on 10/22/12 at					
		cated the resident had					
	' '	e back of his right hand					
		forearm. She indicated					
	and on his left	forearm. She indicated					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155218		ILDING	COMPL 10/23/	ETED		
	ROVIDER OR SUPPLIER	CARE AND REHABILITATION-DYI	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	and monitored resident's care	•						
	on 10/23/12 at residents receive therapy need to	he South Unit Manager 9:10 a.m., indicated ving anticoagulant b be monitored for dicated the resident's as not followed.						
	3.1-35(g)(2)							

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Event ID: PC5M11

Facility ID: 000123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155218	B. WIN	G		10/23/	/2012
NAME OF I	DOLUDED OD GUDDU IEI		•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			2300 G	GREAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	483.25						
SS=E	HIGHEST WELL	E/SERVICES FOR BEING					
		ust receive and the facility					
		necessary care and					
		or maintain the highest					
	practicable physic	l-being, in accordance with					
		ve assessment and plan of					
	care.	To account and plan of					
	Based on obse	ervation, record review	F03	09	1. Resident #34 had no adve	rse	11/22/2012
		the facility failed to			effect. Resident #34 is being		
		cessary treatment and			assessed and monitored prior	to	
		d to assessing a			and after receiving dialysis.		
		o and after receiving			Resident #32, and 57 have a		
	•	f 1 residents reviewed			weekly non pressure sheet completed for their non-pressure sheet	ıre	
		ne facility also failed to			areas. Resident #52 has	ui C	
	,	onitor skin conditions			discharged home.2. All reside	ents	
					receiving dialysis have the		
		ents reviewed for skin			potential to be affected. All		
		ne 8 who met the			residents receiving dialysis ha	ive	
	criteria for skin				a Pre/Post Hemodialysis flow sheet in place to document pr	_	
		related). (Residents			and post dialysis assessments		
	#32, #34, #52	and #57)			and a binder for communication		
		_			with the dialysis center to be		
	Findings includ	de:			maintained with each dialysis		
					service. All residents with		
	1. On 10/16/1				non-pressure skin conditions have the potential to be affect	ad	
	Resident #52 v	was observed with			A head to toe skin assessmer		
	areas of reddis	sh/purple discoloration			has been completed weekly o		
	to his left and r	right forearms.			residents with any non-pressu	ire	
					areas have been documented		
	On 10/18/12 at	t 8:20 a.m., the			and will be monitored weekly		
	resident was o	bserved with a			resolved.3. Education has be completed with nursing staff of	_	
	reddish/purple	bruise to the top of his			dialysis communication with the		
		9:48 a.m., the resident			centers and Pre/Post		
	_	in his wheelchair in the			assessments. Education has		
		ourple bruising was			been provided with all nursing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155218		LDING		10/23/	2012
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE		
					REAT LAKES DR		
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-DY	=R	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed to the	e top of his left and			staff on non-pressure skin		
	right hands.	•			conditions and monitoring.4.		
	9				DNS/Designee will audit week		
	On 10/10/12 at	t 7:56 a.m., 8:55 a.m.,			3months any resident receiving		
		-			dialysis for pre/post assessme	ents	
	-	the resident was again			and communication with the	hor	
		areas of bruising to the			dialysis centers, then every otl week for 3 months. All finding		
	top of his left a	nd right hands.			will be reported in the monthly		
					meeting and the PI commitee		
	The record for	Resident #52 was			then determine if further		
	reviewed on 10	0/19/12 at 8:45 a.m.			monitoring is needed or when		
					100% compliance is		
	Δ Physician's o	order, dated 9/6/12,			achieved. The DNS/Designee	will	
	_	esident was to receive			assess all admissions and		
					readmissions for non-pressure	;	
	•	cation used to prevent			skin conditions and accurate		
	blood clots) an	•			documentation X 3 months. T		
	medication use	ed to prevent blood			DNS/Unit Manager will review weekly skin assessments for	all	
	clots) daily.				accuracy and completion of		
					weekly non-pressure skin		
	Review of the I	resident's current plan			documentation X 3 months, ar	nd	
		ime, indicated the			continue to monitor non-press		
		t have a care plan			skin conditions weekly as an		
		otential for bruising.			on-going practice of this facility		
	related to the p	oteritial for bruising.			All findings will be reported in		
	T. W. H. O.				monthly PI meeting and the PI		
	,	kin Assessments, dated			committee will determine if furt	ner	
		4, 10/11, and 10/18/12,			monitoring needs to be		
	indicated the re	esident had no bruises,			completed or when 100% compliance is achieved after 6	•	
	lesions or skin	tears.			months.	,	
					months.		
	Review of the	Skin inspection section					
		Nursing Evaluation Part					
		2, indicated the resident					
	_	incision to his left hip					
	·	of bruising were					
	documented.						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	ILDING	00	COMPLE	ETED
		155218	B. WIN			10/23/2	2012
			. ,,,,,		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the East Unit Manager					
		2:53 p.m., indicated					
	that a skin ass	essment was to be					
	completed upo	n admission. He					
	further indicate	ed when any type of					
		n tears were observed,					
	_	e skin sheet was to be					
		East Unit Manager was					
		ne areas to the top of					
		eft and right hands and					
		ould look into it.					
	indicated ne w	outa took into it.					
	Further record	review on 10/22/12 at					
		cated a care plan					
		ootential for bruising					
		n 10/19/12 and a					
		der was obtained on					
		31 p.m., to monitor the					
	bruising to both	h hands daily until					
	healed.						
	On 10/19/12 at	t 3:25 p.m., the East					
	Unit Manager i	initiated a "Weekly					
	Non-pressure	Skin Condition" report					
	•	d the resident had a					
		op of the left hand that					
		entimeters (cm) x 4.0					
		uises to the top of the					
		measured 2 cm x 2					
	cm and 6 cm x						
		T OIII.					
	2. On 10/18/1	2 at 1:55 p.m.					
		was observed seated in					
	-	in front of the Nurses'					
	station. She in	ndicated at that time,				l	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155218	B. WI	NG		10/23/2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
			WED		REAT LAKES DR	
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER, I	N 46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG				TAG	BETELEXOTY	DATE
		o dialysis every sday, and Saturday.				
		icated they pick her up				
		m., and she returns to				
		veen 10:00 and 10:30				
	a.m.					
	The record for	Resident #34 was				
		0/18/12 at 2:22 p.m.				
		as admitted to the				
	facility on 7/30/	12 from the hospital.				
	Prior to her hos	spitalization she was				
	residing in ano	ther long term care				
	facility.					
		diagnoses included,				
		nited to, diabetes,				
		lood pressure, renal				
	tailure, and hyp	percholestremia.				
	Devient of the co	dializata a a manazzo i a a ti a se				
		dialysis communication				
	· ·	ndicated the dialysis				
		n papers available for ated 9/17, 9/4, 8/28,				
		There were no other				
	· ·	n forms completed.				
		above mentioned				
		d the dialysis center's				
		ly completed. The				
	l ·	n was incomplete.				
	Further review					
		sheets, indicated the				
		d pressure, pulse and				
		ere to be taken prior to				
	1	dialysis center. There				

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AND PLAN OF CORRECTION 155218 NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER REQUILATORY OR LSC IDENTIFYING INFORMATION) Was also a section on the communication form to describe the resident's condition or if the resident had any problems. Review of the vital signs, indicated the resident's blood pressure was documented on 8/1, 8/8, and 10/1/12. There was no other documentation of the resident's blood pressure in the clinical record. Review of Nursing Progress Notes for the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	RVEY	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER IN 19 SUMMARY STATEMENT OF DERICLENCIES PREFIX (EACH DETICIENCY MUST BE PRECEDED BY FULL REQUATION OF LAKE DETICIENCY MUST BE PRECEDED BY FULL REQUATION OF THE APPROPRIATE Was also a section on the communication form to describe the resident's condition or if the resident had any problems. Review of the vital signs, indicated the resident's blood pressure was documented on 8/1, 8/8, and 10/1/12. There was no other documentation of the resident's blood pressure in the clinical record. Review of Nursing Progress Notes for the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	I DING	00	COMPLETE	ED
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER IX4) ID PREFIX TAG SUMMARY STATEMENT OF DETICIENCIES PREFIX TAG Was also a section on the communication form to describe the resident's condition or if the resident had any problems. Review of the vital signs, indicated the resident's blood pressure was documented on 8/1, 8/8, and 10/1/12. There was no other documentation of the resident's blood pressure in the clinical record. Review of Nursing Progress Notes for the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy			155218				10/23/20 ⁻	12
XINDRED TRANSITIONAL CARE AND REHABILITATION-DYER XINDRED TRANSITIONAL CARE AND REACTOR SIDURISM COMPLETION COMPLET				D. (VII)		ADDRESS CITY STATE ZIP CODE		
CAS D SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS FLAN OF CORRECTION COMPLETION	NAME OF P	ROVIDER OR SUPPLIER	₹					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Was also a section on the communication form to describe the resident's condition or if the resident had any problems. Review of the vital signs, indicated the resident's blood pressure was documented on 8/1, 8/8, and 10/1/12. There was no other documentation of the resident's blood pressure in the clinical record. Review of Nursing Progress Notes for the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy	KINDRED	TRANSITIONAL (CARE AND REHABILITATION-D	YER	1			
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE Was also a section on the communication form to describe the resident's condition or if the resident had any problems.	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy		Paviow of Nur	sing Progress Notes for					
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and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy								
There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy								
available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy		and returning f	rom the dialysis center.					
available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy		There was no	current plan of care					
Review of the current 10/09 "Residents Receiving Dialysis" policy			•					
"Residents Receiving Dialysis" policy								
"Residents Receiving Dialysis" policy		Review of the	current 10/09					
provided by the Director of Nursing,			0 , ,					
indicated "Licensed nurses evaluate			•					
the residents for signs and symptoms			• • • • • • • • • • • • • • • • • • • •					
of infection/bacteremia, bleeding			•					
and/or hemorrhage, septic shock			•					
and/or excess/deficient fluids.								
Licensed nurses manage dialysis								
access site to maintain patency and								
adequate blood flow for dialysis. The		adequate bloo	d flow for dialysis. The					
plan of care includes the directives for		plan of care in	cludes the directives for					
managing the resident's needs for		managing the	resident's needs for					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			IULTIPLE CO LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED	
		100210	B. WIN				23/2012
NAME OF	PROVIDER OR SUPPLIE	R		2300 GF	DDRESS, CITY, STATE, ZIP C REAT LAKES DR	CODE	
KINDRE	D TRANSITIONAL	CARE AND REHABILITATION-D	YER	DYER, I	N 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	end stage rena	al disease."					
	Review of the "Hemodialysis Director of Nur dialysis, licens evaluate the vicommunicate the resident's the last six hou any changes or resident's conclicensed staff vaccess site for unusual redne for bleeding, resident's conclicensed staff vaccess site for unusual redne for bleeding, resident's conclicensed staff vaccess site for unusual redne for bleeding, resident with 11:00 a.m., incomplace on the resident of the access site for the residence of arresidence of arresidence of site access site for the residence of arresidence of site access site for the residence of arresidence of site access site for the residence of arresidence of site access site for the residence of arresidence of site access site for the access						
	1 *	2 was observed on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLET	ED
		155218	B. WIN			10/23/20)12
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	3			REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	10/16/2012 at	10:09 a.m. The					
	resident had a	bruise on the back of					
	his right hand	1 and 1/2 inches in					
	size.						
	On 10/22/12 at	t 11:17 a.m., the					
		bserved in his room					
		wheelchair. There was a					
	_	on the back of his right					
		as a bruise on the					
		ft forearm that was a					
		meter and was purple in					
	color.						
	The record for	Resident #32 was					
	reviewed on 10	0/22/12 at 10:38 a.m.					
	The resident ha	ad diagnoses that					
	included, but w	vas not limited to, lung					
	cancer.						
	There was a C	are Plan that was					
		that indicated the					
	-	t risk for abnormal					
		morrhage due to					
	9	9					
	,	(medications that					
		of blood clots) use					
		madin (a blood thinner)					
	therapy.						
	The intervention						
	- medications a	as ordered					
	-monitor for an	d report to nurse any of					
		igns and symptoms of					
	_	ding gums, nose					
	_	al bruising, tarry/black					
	Sicous, unusue	ar braiding, tarry/black				1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155218	B. WII			10/23/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
אואיסטייי	TDANCITIONAL A	CADE AND DELIABILITATION D	VED		REAT LAKES DR		
		CARE AND REHABILITATION-D	YEK	<u> </u>	N 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		discolored urine		1710			DATE
	•	ins and symptoms of					
	_	ing, ecchymosis,					
	epistaxis)						
	, ,						
	The October 20	012 Physician Order					
		d the resident was					
	receiving Coun	nadin 8 mg (milligrams)					
	every other day	y alternating with					
	Coumadin 7.5	mg every other day.					
	•	kin Check" form					
	•	10/16/12, indicated					
		non-pressure skin					
	concerns.						
	The resident w	as discharged to the					
		17/12 at 7:01 a.m. The					
	· •	eadmitted to the facility					
	on 10/19/12.	darrintod to the identy					
	· · · · · · · · · · · · · · · · · · ·						
	The "Skin Insp	ection Anatomy					
	•	, dated 10/20/12,					
	indicated the re	esident had no open					
	areas and no n	on-pressure areas.					
		ursing Evaluation"					
	form, dated 10	•					
		the facility, indicated					
		skin was supple, normal					
	and free from o	ppen areas.					
	Intomicus	DN #2 on 40/22/42 =+					
		_PN #2 on 10/22/12 at					
	-	icated that when a					
	bruise was not	ยน แ พลร เบ มย					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155218	B. WIN			10/23/2012
			D. 111		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR	
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER	1	IN 46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	documented of	n the "Non-Pressure				
	Skin Condition	" form and it was to be				
	monitored wee	kly until resolved. She				
		when a resident was				
	admitted or rea	admitted to the facility				
		to do a skin inspection				
		nd was to document the				
		Patient Nursing				
	Evaluation" for	•				
		III.				
	Th	and days and the standard and				
		evidence the bruise on				
		resident's right hand				
		that was on the				
		orearm was assessed				
	and monitored	before discharge to				
	the hospital an	d upon return from the				
	hospital.					
	LPN #2 comple	•				
	Non-Pressure					
	Reports" for th	e resident on 10/22/12				
	at 12:35 p.m.	She indicated the				
	resident had a	bruise on his left				
	forearm that w	as 1.3 cm x 1.2 cm				
	(centimeters) i	n size and was purple				
	`	also indicated the				
		bruise on the back of				
		that was 3 cm x 3.2				
	cm in size.	. Clat was 5 oill x 5.2				
	GIII III 3IZE.					
	Intonious	LPN #2 on 10/22/12 at				
	•	cated the resident had				
		e back of his right hand				
		forearm. She indicated				
	the areas shou	ıld have been assessed				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-D	YER	1	N 46311		
(X4) ID	CIMMADV	STATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		<u> </u>	-	ino			DATE
	1	re first observed by					
	staff.						
		7 was observed on					
	10/15/12 at 1:	55 p.m. The resident					
	had 2 fading b	oruises noted on the left					
	forearm.						
	On 10/17/12 a	t 9:04 a.m., the					
	resident was u	ıp in a Broda chair. He					
		n in diameter bruise on					
	the back of his						
	life back of file	e lett flaffd.					
	The record for	Resident #57 was					
		0/17/12 at 8:47 a.m.					
		ad diagnoses that					
	· ·	vere not limited to,					
		entia and Parkinson's					
	disease.						
	The October 2	012 Physician Order					
	Sheet, indicate	ed the resident received					
	325 milligrams	s (mg) of aspirin daily.					
		-					
	Review of the	"Weekly Skin Check"					
		10/8/12 and 10/15/12,					
		esident had no skin					
		changes, no ulcers, or					
		manges, no dicers, or					
	injuries.						
	Interview with	LPN #1 on 10/17/12 at					
		dicated when a bruise					
		as noted, it was to be					
	documented o	•					
	Non-pressure	Skin Condition" form.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETE	D
		155218	B. WIN			10/23/201	12
			b. Wilv		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			REAT LAKES DR		
KINIDDEL	TDANSITIONAL (CARE AND REHABILITATION-D	VED		N 46311		
			I LIX	<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re CC	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	She indicated i	it was then monitored					
	weekly until it v	was resolved.					
	Interview with I	LPN #1 on 10/17/12 at					
	2.40 p m india	cated the resident did					
	•	red area on the back of					
		She indicated when it					
		, it should have been					
	assessed and	documented.					
	The policy title						
	Ulcer/Non-Pres						
	Assessment" v	vith a revision date of					
	8/31/12, was p	rovided by the					
		Set (MDS)Coordinator					
		2. She indicated the					
		rent. The policy					
	indicated, "Pre	· •					
	•						
	•	sure ulcer assessment					
	•	t least weekly to					
		progress of healing, the					
	presence of po	ssible complications					
	(e.g. signs of ir	ncrease in area of					
	ulceration or so	oft tissue infection), the					
		nin (e.g., is it being					
		ntrolled,) and the status					
		rounding the ulcer (that					
		ed without removing the					
		ed without removing the					
	dressing)."						
	Daviday: -£41-	Novembra Deserva					
		Nursing Progress Note,					
	dated 10/17/12	•					
	indicated, "Wri	ter informed by unit					
	manager of dis	scoloration to posterior					
	left hand and le	eft posterior forearm."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain -monitor for skin integrity STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311 (X5) PROVIDER PLAN OF CORRECTION (EACH OFFICIENCY) PROVIDER PLA	STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER (X4) ID PREFIX TAG There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain			155218				10/23/	2012
XINDRED TRANSITIONAL CARE AND REHABILITATION-DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain 2300 GREAT LAKES DR DYER, IN 46311 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain				b. Wilv		ADDRESS CITY STATE ZIP CODE		
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain DYER, IN 46311 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain	NAME OF	PROVIDER OR SUPPLIEF	R					
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain	KINIDDE	D TDANGITIONAL (CADE AND DEHABII ITATION DA	/ED				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain	KINDIKL	.D ITANOITIONAL (CARE AND REHADILITATION-DI	LIX	DILIX, I			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE THERM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE TAG TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE TAG TAG TAG TAG TAG TAG TAG		SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain		, and the second				CROSS-REFERENCED TO THE APPROPRIA	TE	
10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Interview with the South Unit Manager on 10/23/12 a 9:10 a.m., indicated the bruises noted on the resident's arms were not assessed when first identified by staff. She also indicated the resident's left hand that was 1.5 centimeters (cm) x 1.2 cm in size and was purple in color. Interview with the South Unit Manager on 10/23/12 at 9:10 a.m., indicated the bruises noted on the resident's arms were not assessed when first identified by staff. She also indicated the resident's bruises were not monitored weekly. 3.1-37(a)		10/17/12 that in ecchomysis (by posterior hand) areas to resolve monitor for parameters for skin ending the "Weekly Not assessment, do indicated there area to the back hand that was 1.2 cm in size a color. Interview with the on 10/23/12 at the bruises not arms were not identified by state resident's be monitored weekly size and the size of the resident's be monitored weekly size and the size of the resident's be monitored weekly size of the resident's believes	ndicated: bruising) spots to left ve thru next review in in integrity hanges lon-pressure Skin" ated 10/17/12, was a non-pressure ck of the resident's left 1.5 centimeters (cm) x and was purple in the South Unit Manager 9:10 a.m., indicated ted on the resident's assessed when first aff. She also indicated bruises were not					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

		166010	A. BUILDING B. WING	00	COMPLETED 10/23/2012
		CARE AND REHABILITATION-DYE	2300	GADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DR R, IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER						
KINDDE	D TO A NOITION AL C	SADE AND DELIADILITATION DV	-D		REAT LAKES DR		
KINDKEI	J TRANSITIONAL C	CARE AND REHABILITATION-DY	EK	DIEK,	IN 46311		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	. =	DATE
	483.25(a)(3) ADL CARE PROVERSIDENTS A resident who is activities of daily I necessary service nutrition, groomin hygiene. Based on obse and interview, the ensure depends transferred out residents reviews services. (Residents at 10:45 a.m., 10.11.20 a.m., 11.20 a.m., 11.20 a.m., and residents on the eating breakfast On 10/17/12 at 11:20 a.m., 12:3:15 p.m., the resident and the residents on the eating breakfast on the residents on the eating breakfast on 10/17/12 at 11:20 a.m., 12:3:15 p.m., the resident at 12:20 a.m., the resident and the residents on the eating breakfast on 10/17/12 at 11:20 a.m., the resident and the residents on the eating breakfast on 10/17/12 at 11:20 a.m., the resident at 12:20 a.m., the resident at	unable to carry out living receives the es to maintain good g, and personal and oral ervation, record review the facility failed to lent residents were of bed for 1 of 1 wed for hospice dent #83) e: esided on the South observed on 10/15/12 12:40 p.m. and at 2:30 ent was in bed in her as observed on 9 a.m., 10:29 a.m., 11:30 p.m. The bed. At 8:19 a.m., the est in the dining room. 8:18 a.m., 10:15 a.m., 2:1 p.m., 2:07 p.m. and resident was observed ent was observed ent year.	F03	TAG	1. Resident #83 is offered to be out of bed for 3 meals a day per her preference. 2. All residents dependent on staff for transfers to get out of bed have the potential to be affected. All C.N.A. sheets have been update to reflect when dependent residents are to be out of bed. The DNS/Designee will complet twice daily rounds to ensure all dependent residents are assist up out of bed per plan of care. Education has been completed with nursing staff on Activities Daily Living.4. The DNS/Designee will complete twice daily rounds to ensure residents dependent on staff for transfers to get out of bed are assisted out of bed per plan of care x 5 days a week for 3 months, then daily x 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100 compliance has been achieved.	y or e lated ted 3. d of or	
	10/16/12 at 8:1 11:20 a.m. and resident was in residents on the eating breakfas On 10/17/12 at 11:20 a.m., 12: 3:15 p.m., the r in bed. At 12:2	9 a.m., 10:29 a.m., 11:30 p.m. The bed. At 8:19 a.m., the e South Unit were st in the dining room. 18:18 a.m., 10:15 a.m., 21 p.m., 2:07 p.m. and resident was observed 21 p.m., the residents init were eating lunch		DNS/Designee will complete twice daily rounds to ensure residents dependent on staff for transfers to get out of bed are assisted out of bed per plan of		the % d or	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND FLAN	OF CORRECTION	155218		LDING	00	10/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-DY	ÆR	DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	10/18/12 at varante resident varante residents on the dining room breakfast. Residents on the dining room breakfast. Resident varante va	at 8:12 a.m., the me South Unit were in me being served sident #83 was in the Resident #83 was 0/17/12 at 1:13 p.m. and diagnoses that were not limited to, shorea, dysphagia lowing) and The resident had been rvices since 3/18/12. 2012 Physician Order ed the resident was to ated, not for greater per family request. Minimum Data Set					

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Event ID: PC5M11

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155218	B. WIN			10/23/2012
			b. Wil		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	R			REAT LAKES DR	
KINIDREI	TRANSITIONAL (CARE AND REHABILITATION-D	VER		IN 46311	
					114 +0011	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	severely impair	red in her decision				
	making ability a	and required extensive				
	assistance of 2	2 staff members for				
	transfers.					
	The Care Plan	that was revised on				
		ted the resident				
	-	sive assist with adl's				
	-	aily living) due to the				
	•					
	_	untington's chorea.				
		terventions were:				
		ist with bed mobility,				
		ing, and hygiene				
	-up for all meal	ls				
	-assist residen	t out of bed when she				
	wakes up as so	oon as possible				
	-	•				
	The Care Plan	, dated 10/8/12,				
		esident had an adl self				
		nce deficit related to the				
	need for assist					
	•	condary to muscular				
	· ·	ment. The interventions				
	included:					
	,	nt's name) choices and				
	•	nenever possible				
	-limit time up ir	n Broda chair to no				
	more than 2 ho	ours per family request				
	The South Unit	t CNA (Certified				
	Nursing Assist	ant) assignment sheet				
	_	It indicated the				
		be, "up for all meals."				
		, - 				
	Review of the i	progress notes, dated				
		p. 55, 555 Hotos, datod				1

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AND PLAN OF CORRECTION 155218 155218 10/23/2012		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER X1 ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG 10/13/12 through 10/19/12, indicated there was no evidence the resident had refused to get out of bed. On 10/19/12 at 8:25 a.m., LPN #3 was interviewed. She indicated the resident would flail her arms and become agitated when staff attempted to get her out of bed. On 10/19/12 at 8:26 a.m., LPN #3 entered the resident's room. LPN #3 asked the resident if she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		
CALL CONTROL OF PROVIDER OR SUPPLIER			100210	B. WI			10/23/	12012
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION (EACH) COMPLETION DATE 10/13/12 through 10/19/12, indicated there was no evidence the resident had refused to get out of bed. On 10/19/12 at 8:25 a.m., LPN #3 was interviewed. She indicated the resident would flail her arms and become agitated when staff attempted to get her out of bed. On 10/19/12 at 8:26 a.m., LPN #3 entered the resident's room. LPN #3 asked the resident fi she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.	NAME OF I	PROVIDER OR SUPPLIER						
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had refused to get out of bed. On 10/19/12 at 8:25 a.m., LPN #3 was interviewed. She indicated the resident will refuse to get out of bed. She indicated the resident would flail her arms and become agitated when staff attempted to get her out of bed. On 10/19/12 at 8:26 a.m., LPN #3 entered the resident's room. LPN #3 asked the resident if she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.			•					
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Staff attempted to get her out of bed. On 10/19/12 at 8:26 a.m., LPN #3 entered the resident's room. LPN #3 asked the resident if she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.								
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asked the resident if she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.		On 10/19/12 at	: 8:26 a.m., LPN #3					
get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.		entered the res	sident's room. LPN #3					
The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m.		asked the resid	dent if she desired to					
Broda Chair on 10/19/12 at 9:38 a.m.		get up. The res	sident mumbled, "yes".					
Broda Chair on 10/19/12 at 9:38 a.m.		The resident	aa ahaamkad uu in a					
			•					
the dining room. An activity was			•					
being set up in the dining room. The			-					
resident was calm and there was no			•					
evidence of agitation noted. The								
resident was not flailing her arms.		_						
Observation of the resident on		Observation of	the resident on					
10/19/12 at 10:30 a.m., indicated the		10/19/12 at 10:	30 a.m., indicated the					
resident remained up in the Broda		resident remain	ned up in the Broda					
chair. The resident was reclining in		chair. The resid	dent was reclining in					
the chair, there were no signs of		the chair, there	were no signs of					
agitation noted, her eyes were closed		agitation noted	, her eyes were closed					
and she was resting.		and she was re	esting.					
Interview with the South Unit Manager on 10/19/12 at 8:29 a.m., indicated			_					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE COMPI 10/23	LETED
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DYE	2300 0	ADDRESS, CITY, STATE, ZIP COD GREAT LAKES DR , IN 46311	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the resident had not been up in the Broda chair and had not been up for meals 10/15/12 through 10/18/12. She indicated the staff should have gotten the resident out of bed. 3.1-38(a)(2)(B)				

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Event ID: PC5M11

Facility ID: 000123

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2300 G	REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DYI	ΞR	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=D	483.25(c) TREATMENT/SV PRESSURE SOF Based on the con a resident, the fac resident who ente pressure sores de sores unless the condition demons unavoidable; and sores receives ne services to promo infection and prev developing. Based on obse and interview, the ensure nutrition on the status of ulcer were implemanner for 1 of who met the cr ulcers. (Reside Findings includ On 10/17/12 at #53 was obsert dressing to her dated 10/16/12 On 10/18/12 at resident had pr in place to both	Inprehensive assessment of cility must ensure that a sers the facility without one not develop pressure individual's clinical strates that they were a resident having pressure excessary treatment and one healing, prevent event new sores from ervation, record review the facility failed to hal interventions based of a resident's pressure elemented in a timely of 3 residents of the 4 siteria for pressure ent #53) Ide: 18:17 a.m., Resident ent wed with a gauze of left foot that was entered in the elemented in the	F03	TAG	1. Resident #53 has all RD recommendations oredered ar implemented. 2. All residnets with a pressure ulcer and a nutritional intervention recommended by the RD have the potential to be affected. A residents with a pressure ulcer have been reviewed to ensure RD recommendations for nutritional interventions are implemented. 3. Education has been completed with licensed nurses and nursing managers implementation of nutritional interventions timely.4. The DNS/Designee will review, with the RD ,weekly in the NAR meeting for weekly implementation of all nutritional recommendations as an on go practice of this facility and sign the weekly RD nutritional recommendations sheet to ver	nd s ill s on h	DATE 11/22/2012
	resident was w	: 11:40 a.m., the rearing a pressure on her left foot.			completion. All findings will be reported in the monthly PI meeting and the PI commitee determine if 100% compliance	will	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	ILDING	00	COMPLETED
		155218	B. WIN			10/23/2012
		_			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER			REAT LAKES DR	
KINDRE	D TRANSITIONAL	CARE AND REHABILITATION-D	YER		IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	+-	TAG	DEFICIENCY)	DATE
					has been achieved or if furhte monitoring is required.	ſ
		at 2:55 p.m., the			monitoring is required.	
	dressing to the	e resident's left foot was				
	removed. The	e resident was observed				
	to have suture	es to the left plantar				
	aspect of her	foot. Interview with LPN				
	#7 at the time	, indicated the resident's				
	foot had been	sutured close by the				
		nid in healing. She				
		area was approximately				
		lime prior to being				
	sutured close.					
		•				
	The record for	r Resident #53 was				
		0/18/12 at 1:38 p.m.				
		diagnoses included,				
		•				
		imited to, history of				
	•	espiratory failure,				
		, and gastrostomy (a				
		serted into the				
	stomach).					
		vices note, dated				
	· ·	ated the resident was				
	_	ficant weight loss at				
		I month and multiple				
	impaired skin					
	recommendat	ion was made to				
	increase the r	esident's tube feeding				
	of Glucerna 1	.2 to 1 can, 6 times a				
	day. Continue	flushes as ordered.				
	Documentatio	on in the nutrition				
	services notes	s, dated 10/1/12,				
		resident was seen by				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	ILDING	00	COMPLE	TED
		155218	B. WII			10/23/2	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		es related to low					
	•	umin levels. The					
		ued to have a Stage 4					
	•	to the foot. Other area					
	to back healed	. Medications include					
	Vitamin C and	multi-vitamin. Concur					
	with prior recor	nmendation to					
	increase Gluce	rna 1.2 to 6 cans/day.					
	Documentation	completed by the					
		titian (RD) on 10/6/12,					
	•	. ,					
		ollowing: "RD review for					
	weight loss -12						
	month/14.2 lbs						
		s significant, continues					
	with Stage 4 to	•					
	receiving antibi						
		ction, along with					
		crease caloric needs.					
		(nothing by mouth)					
		of Glucerna 1.2, 5 cans					
	a day. Recomi	mendation to increase					
		cans a day made 9/25					
	and 10/1/12. N	lo notice if MD agreed					
	or disagreed w	ith RD					
	recommendation	on. Per NAR (nutrition					
	at risk) notes, r	nursing states resident					
	•	use a feeding. RD					
		same per med sheets					
		y. No residuals noted					
	_	es. Please verify					
	actual volume	•					
		f verified that resident					
		5 cans day, could be					
	_	weight loss. If verified					
		weight 1033. II vehilled	1				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
	155218	B. WI			10/23	/2012
	l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER			REAT LAKES DR		
KINDREI	D TRANSITIONAL CARE AND REHABILITATION-DY	ER		IN 46311		
(VA) ID	CLIMMADV CTATEMENT OF DEFICIENCIES	T	ID			(V5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710	,	+	ino	·		DATE
	resident is not tolerating current					
	prescribed volume, may want to					
	consider 1.5 calorie feeding."					
	A nutrition services note completed					
	10/10/12, indicated the reason for the					
	visit was based on a conversation					
	with the Nurse Practitioner, the					
	resident's albumin was low at 2.8,					
	also spoke with nurse who stated					
	resident was not refusing feedings.					
	Phone consult with RD, recommend					
	change feedings to Jevity bolus 1 can					
	5 times a day, add promod (a protein					
	supplement) 1 scoop twice a day					
	through the gastrostomy tube.					
	A Dhysiciania arden detect 10/10/10					
	A Physician's order, dated 10/12/12,					
	indicated to change the feeding					
	formula to Jevity 1.5-1 can bolus 5					
	times daily. Continue same flush					
	orders. Begin promod 30 milliliters					
	(ml) twice a day.					
	Interview with the District Director of					
	Clinical Operations on 10/23/12 at					
	3:00 p.m., indicated the dietary					
	recommendations should have been					
	followed- up on in a more timely					
	manner.					
	3.1-40(a)(2)					
	0.1 ¬υ(α)(Δ)					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	S.			REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.25(d) NO CATHETER, BLADDER Based on the resi assessment, the resident who ente indwelling cathete the resident's clin that catheterization resident who is in receives appropri to prevent urinary restore as much re possible. Based on obse and interview, the ensure there we justification for Foley (urinary) residents of the	PREVENT UTI, RESTORE ident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless ical condition demonstrates on was necessary; and a accontinent of bladder tate treatment and services or tract infections and to normal bladder function as ervation, record review, the facility failed to eas a medical the continued use of a catheter for 2 of 3 e 3 who met the criteria meters. (Residents #53	F03	TAG		ave	
	Interview wi	th LPN #8 on 10/15/12			Justification for Indwelling Catheter Use. 4.The DNS/Designee will rev	/iew	
	•	dicated Resident #53			all resident's admitted with an	-	
		theter in place due to			indwelling catheter or with an		
	•	2 pressure ulcer to			order for placement of an		
	her coccyx.				indwelling catheter to determing the need for the initiation and the i		
	On 10/17/12 at	: 8:17 a.m. and 11:20			continued need for indwelling		
		ent was observed with			catheter use or if the condition can be modified, maintained,		
	a Foley cathete				reversed, and/or eliminated, or	nce	
	- 1 111y 000.000	F			weekly for 6 months and all		
	The record for	the resident was			findings reported to the PI		
					committee in the PI meeting		
	reviewed on 10	0/18/12 at 1:38 p.m.			monthly or until 100% complia	nce	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DDIC	00	COMPL	ETED
		155218	A. BUI B. WIN	LDING		10/23/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			REAT LAKES DR		
KINDREI	D TRANSITIONAL (CARE AND REHABILITATION-DY	'FR		IN 46311		
				·	114 40011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG		NI.	DATE
		mission assessment,			is met as determined by the P committee.	1	
	indicated the resident was admitted with a Stage 2 pressure area to her left buttock which measured 7.5				committee.		
	centimeters (ci	m) x 4.0 cm.					
	The "medical j	ustification for an					
	indwelling cath	eter" form, dated					
	_	ed the Foley catheter					
		ed due to contamination					
	_	essure ulcers with					
		s impeded healing,					
		oriate personal care for					
		ce. Underlying factors					
		initiation/continuation					
		, wound on coccyx.					
		vill be removed once					
		ealed. Family aware of					
		e indwelling Foley					
		idary to wound healing.					
	Goal to avoid of	contamination to the					
	wound and sur	rrounding area."					
	The resident w	as readmitted to the					
	facility on 8/23	/12 following a					
	· ·	. The readmission					
	-	dicated the resident					
		re sores, however; the					
		n order for the Foley					
	catheter.	5. 35. 15. 115 1 516y					
	Janicier.						
	An entry in the	Nursing progress					
	,	0. 0					
	'	0/17/12 at 10:36 a.m.,					
		lurse Practitioner was					
	reviewing a ne	ed for the diagnosis for					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155218	B. WIN			10/23/2	012
		<u> </u>	b. Wil		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
KINDDE		CARE AND DEHABILITATION D	VED		REAT LAKES DR		
KINDKEL	J TRANSITIONAL (CARE AND REHABILITATION-D	IEK	DIEK, I	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the Foley cathe	eter. A					
	•	on was made to					
		e Foley catheter.					
		or oley datricter.					
	A Dhuaisianta a						
	_	order, dated 10/17/12,					
		scontinue the Foley,					
	monitor voiding	g pattern and intake					
	and output for	72 hours.					
	Interview with	the District Director of					
	Clinical Operat	tions on 10/23/12 at					
	•	licated the resident's					
	· ·	een removed and there					
	•	ation why the catheter					
		se since readmission on					
	8/23/12.						
	2. On 10/17/1	2 at 8·24 a m					
		was observed in bed.					
		as noted with an					
	indwelling Fole	ey catneter.					
	The record for	Resident #165 was					
	reviewed on 10	0/18/12 at 10:02 a.m.					
	The resident w	as admitted to the					
	facility on 3/15						
	13.0	· · - ·					
	The resident's	diagnoses included,					
		mited to, endocarditis,					
		ess, spinal stenosis,					
	chronic kidney	disease, high blood					
	pressure, hypo	smolity, hyponatremia,					
		fection, and anemia.					
	,	,					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUI	A. BUILDING 00			COMPLETED	
		155218	B. WIN	IG		10/23	/2012	
NAME OF I	PROVIDER OR SUPPLI	ER		1	ADDRESS, CITY, STATE, ZIP CODE			
KINIDDE	D TDANGITIONAL	. CARE AND REHABILITATION-I	NED		REAT LAKES DR			
	1		JIEK		IN 46311		_	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION	
TAG	`	OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE	
		ysician Orders, dated						
		ated Foley catheter 18						
	•	ibic centimeters (cc).						
		,						
	Review of Ph	ysician Progress notes,						
	dated 6/13/12	2, indicated Urinary Tract						
		ncomycin Resistant						
	,	VRE) Pseudomonas						
	completed with	th antibiotic treatment.						
		rinalysis culture						
		10/11/12, indicated the						
		greater than 100,000						
	l •	s aeruginosa in which ed with an antibiotic.						
		did not have a VRE						
	infection in he							
		or utility.						
	Review of the	"Medical justification for						
		use" form, dated 6/13/12,						
		form was incomplete						
	related to the	medical justification for						
	the catheter.	Further review indicated						
	under the sec	tion "What are the plans						
	to discontinue	e the indwelling						
	catheter? indi	cated treat VRE with						
	antibiotic (AB	T)."						
		the West Unit Manager						
		at 1:40 p.m., indicated						
	_	s for the Foley catheter						
		infection in her urine. ager thought having an						
		RE was an acceptable						
		the Foley catheter.						
	I mulcation ioi	uic i diey cauletel.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155218		ILDING	00	COMPL 10/23/	ETED
	PROVIDER OR SUPPLIER D TRANSITIONAL (CARE AND REHABILITATION-DY	ΞR	2300 GF	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Director of Nurse 3:50 p.m., indicated in medical justification Foley catheter, she had called received an ordinary.	the Regional Interim sing #1 on 10/18/12 at cated there was no ation for the indwelling. She further indicated the physician and der today to remove the to the resident did in her urine.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					r í	E SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		LETED	
		155218	B. WIN			10/23	3/2012	
	n overnoon on				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				REAT LAKES DR			
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0323 SS=G	483.25(h) FREE OF ACCID HAZARDS/SUPE The facility must environment remains hazards as is possible receives adequated assistance devices. Based on obset and interview, ensure fall previous for 1 of 3 accidents of the criteria for a deficient praction requiring the resultures. (Residents of accidents of met the criteria (Resident #155) Findings included 1. Resident #65 Tindings i	ENT ERVISION/DEVICES ensure that the resident ains as free of accident esible; and each resident es to prevent accidents. ervation, record review the facility failed to vention devices were in residents reviewed for e 11 residents who met accidents. This ce resulted in an injury esident to receive lent #62) The facility elitiate a fall intervention a residents reviewed f the 11 residents who for accidents. Example 12 was observed on example 2 was observed on example 3 was observed on example 4 a.m. She was example 3 was observed on example 4 a.m. The resident example 5 was observed on example 6 was observed on example 7 was observed on example 6 was observed on example 7 was observed on example 6 was observed on example 7 was observed on example 8 was observed on example 9 was observed	F03		1. Resident # 62 has had interventions updated. Res 155 has had all interventio initiated.2. All residents w interventions or recommendations for fall interventions have the pote be affected. An audit of al residents with a fall has be completed for the past 30 for implementation of recommended intervention with the C.N.A. sheet for interventions communicate the C.N.A. sheet.3. Educa Accidents and Supervision been completed with all department heads and nur staff.4. The IDT will comp safety rounds twice daily w C.N.A sheets to validate fainterventions are implementations are implementations. All sheets signed and the rounds will be completed in the IDT AM metality at a month to report findings X 3 month the rounds will be completed in the monthly meeting and the PI commit determine if 100% compliants.	fall sident # ns ith fall ential to leen days and ed on ation on a has esting lete with the all ented en eeting ches, eted engs will PI tee will ince	11/22/2012	
	seated in a Bro	oda chair in the West			has been achieved or if fur			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	₹			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	ÆR		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG				IAG	monitoring is required.		DATE
		m. She had a self			informoring is required.		
		, there was no pull tab					
	alarm attached	I to the resident.					
	On 10/17/12 at 12:40 p.m., the resident was in the Broda chair in the dining room. There was no pull tab alarm attached to the resident. There						
	was a self rele	ase seat belt in place.					
	The resident w	as observed on					
		20 p.m., she was					
		Broda chair in front of					
		ation. There was a self					
		elt in place, there was					
		m attached to the					
	resident.	in attached to the					
	resident.						
	On 10/18/12 a	t 8:15 a.m., the					
	resident was u	p in the Broda chair					
	with a self rele	ase seat belt in place,					
		oull tab alarm in place.					
		t 1:55 p.m., the					
	resident was o	_					
		m the Broda chair to					
	_	A #1 and CNA #2. The					
	self release se	at belt was on the					
	resident. There	e was no Dycem (a					
	material used	to prevent sliding) in					
	the chair unde	r the resident and there					
	was no pull tat	o on the chair attached					
	to the resident						
	Interview with	CNA #1 on 10/18/12 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/23/	ETED	
		155216	B. WIN	G		10/23/	2012
	PROVIDER OR SUPPLIER	CARE AND REHABILITATION-DY	ER	2300 GI	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	Dycem and no resident. Conti CNA #1, indica applied the pul seat belt was a CNA #1 had th Assignment Sh	cated there was no pull tab alarm on the nued interview with ited she had not I tab alarm since the ipplied. e West Unit CNA neet in her pocket. On 55 p.m., the CNA					
	assignment she indicated the re low bed with a release belt, a bed, a pull tab	eet was reviewed. It esident was to have a mat at bedside, a self pressure alarm to the to chair, a cushion with foot buddy to the Broda					
	reviewed on 10 The resident had included, but w	Resident #62 was 0/18/12 at 2:08 p.m. ad diagnoses that vere not limited to, ular degeneration and					
	Data Set (MDS assessment re 9/26/12, indica long and short problems and rassistance of 2 transfers. It als resident's balar	required extensive staff members with					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155218	A. BUI B. WIN			10/23/	/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		1	REAT LAKES DR		
KINIDDEI	TDANGITIONAL	CARE AND REHABILITATION-D	VED		IN 46311		
KINDKEL	J TRANSITIONAL I	CARE AND REHABILITATION-D	ILK	DIEK,	110 403 1 1		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	standing positi	on and during					
	transfers.						
	A fall risk asse	ssment was completed					
	on 9/11/12 and 9/21/12. Both assessments indicated the resident						
		75, which indicated a					
	high risk for fal						
	Dovious of the	resident's record,					
		•					
	indicated the resident had falls on 6/19/12, 7/6/12, 7/15/12, 7/20/12,						
	7/25/12, 8/4/12	2, 9/6/12 and 10/5/12.					
	Review of the	form titled "Post Fall					
	Evaluation Par	t 2 IDT					
	(Interdisciplina	ry Team) Review" that					
	was dated 9/18	8/12, indicated the					
		fall on 9/6/12. The					
		After Fall" section of					
		ated the intervention					
	•	after the fall was a seat					
	belt.						
		hysician's Order, dated					
		ndicated the resident					
	was to use a s	elf-releasing seat belt.					
	There was a F	alls Care Plan with a					
	revision date o	of 9/20/12, that					
		esident was at risk for					
	falls due to uns						
	psychoactive of	• •					
		-					
		n/comprehension,	- [
	disease proces	ss condition, and					İ

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETE	
		155218	B. WIN			10/23/201	12
NAME OF D	PROVIDER OR SUPPLIER	2	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF F	NO VIDER OR SUITEE				REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER, I	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CC	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		interventions to be					
	used to prever	it falls were:					
	-Broda chair fo	or proper positioning					
	-concave matti						
	-Dycem to Bro						
		nat next to bed					
	-pressure alarr						
	-pull tab alarm						
	•	heelchair belt to Broda					
	chair						
	The October 2	012 Physician Order					
	Sheet indicate	d the resident was to					
	have a pull tab	alarm to the					
	wheelchair and	d a wheelchair cushion					
	with Dycem.						
		ad a fall on 10/5/12 at					
		eview of the form titled,					
		luation Part 1," dated					
	· ·	ited the resident had a					
		with injury. She was					
		the hospital. The					
		ed forward from her					
		id hit her face on a					
		ling room. The staff ted the resident to the					
		as no evidence that the					
		ns were in place prior to					
	the fall.	is were in place prior to					
	uiciaii.						
	The form titled	"Post Fall Evaluation					
		/iew" dated 10/8/12					
		It indicated the					

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	OF CORRECTION OF CORRECTION 155218	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/23/2012			
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DYE	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE			
	resident received sutures above her right eye brow while in the Emergency Room. The interventions at the time of the fall included, Broda chair, under direct supervision of staff, in the west assisted dining room during an activity, attending a group activity listening to music, "nurse was on seen [sic] immediately and first aide was initiated resident was sent to ER for evaluation, updated doctor on blood pressures and meds (medications) for review due to low blood pressure, will re-educate CNA's on restraint use." There was a progress note dated 10/5/12 at 4:00 p.m. "Res.(resident) returned from ER. Noted with 3 sutures to rt.(right) eyebrow. No active bleeding noted, No signs of pain/discomfort. POA (Power of Attorney) notified of res . return and is on her way to facility. Report called from hospital stating all CT scans were negative" Review of the Emergency Department notes, dated 10/5/12, indicated, "Pt. (patient) arrives BLS (Basic Life Support) via (Name if Ambulance company) to Room 3B c/o (complaint) facial lacerations r/t (related to) witnessed fall at nursing home. Pt. is awake and alert only to self per						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. ВІЛІ	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			REAT LAKES DR		
KINDREI	D TRANSITIONAL (CARE AND REHABILITATION-DY	ΞR		IN 46311		
			1				(375)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		,		IAG	,		DATE
		d EMS (Emergency					
	,	Pt. is longboarded					
		abilization with rolled					
		notes small laceration					
	_	pleeding controlled with					
	•	me. Dentition cracks					
	noted, but uns	ure if this is new to					
	today's injury.	Pt. non-verbal with					
	staff. EMS sta	tes that this is her					
	norm. 1 cm (ce	entimeter) laceration					
	•	eyebrow, to right of					
	_	tear note, V shaped, 1					
		losure: 5-0 nylon,					
	1	ures 3. technique:					
		g 4 x 4 sterile gauze."					
	Simple diessim	g + x + sterile gauze.					
	Intonvious with	the West Unit Manager					
		the West Unit Manager					
		2:15 p.m., indicated					
		d not have a self					
		, as ordered by the					
	1	ne time of the fall on					
		ndicated the resident					
		by a Hospice CNA who					
		ne seat belt on the					
	resident. She a	also indicated facility					
	staff did not ap	ply the seat belt after					
	Hospice staff le	eft.					
	The form titled	(Name of Hospice					
		spice "Incident Report					
		," dated 10/5/12, was					
	_	dicated, "Staff at					
		e) Nursing facility					
	•	ient fell from Broda					
	-						
	Chair Striking n	er head, resulting in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155218	B. WII			10/23/2012
(E. O.E. P.				STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L		2300 GF	REAT LAKES DR	
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER, I	N 46311	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	need for emerg	gency hospital visit. Our				
	HHA (Home He	ealth Aide) had gotten				
	patient up at 7:	15 a.m., did care, and				
	when she left fa	acility patient was fully				
	reclined in Brod	da and next to the				
	Nurses' station	. The fall occurred at				
		11:00 a.m. The seat				
		stened/secured and				
	was underneat					
		F				
	Interview with t	he West Unit Manager				
	on 10/18/12 at	2:30 p.m., indicated				
	the resident ha	d Physician's Orders				
	for a pull tab al	arm and for Dycem in				
	the chair. She i	indicated the fall				
	devices were n	ot in place as ordered				
		tions on 10/17/12 and				
		indicated the devices				
	should have be					
		on in place.				
	2. On 10/17/12	2 at 8:22 a.m				
		was observed sitting in				
		ating breakfast in the				
		the West Unit. The				
	_	bserved with a clip				
		•				
		ached to her and the				
	wheelchair.					
	The record for	Resident #155 was				
	reviewed on 10)/17/12 at 8:47 a.m.				
		as admitted to the				
		/12 from the hospital.				
	idomity on orzin	12 Hom the mospital.				
	The resident's	diagnoses included,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155218	B. WIN	NG		10/23/	2012
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TDANIOITIONAL	CARE AND DELIABILITATION D	/ FD		REAT LAKES DR		
	TRANSITIONAL	CARE AND REHABILITATION-D	YEK	DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		mited to, acute pain , muscle weakness,					
		fection, chronic					
	1	ase, dysphagia,					
		ar disease, high blood					
		ory of falls, depressive					
	disorder, and i						
		noomina.					
	Review of Phy	sician Orders, dated					
	_	ed to place the bed					
	· ·	III. A Physician Order,					
	•	indicated pull tab					
	•	Ichair, place bed					
		ill and pull tab alarm to					
	be used in bed	•					
	Review of the	Patient Evaluation,					
		indicated the resident					
	was a medium	ı risk for falls.					
	Review of the	Minimum Data Set					
	(MDS) admiss	ion assessment, dated					
	9/3/12, indicate	ed the resident was					
	alert and orien	ted times three, she					
	needed extens	sive assist with one					
	person physica	al assist for bed					
	mobility, transf	fers, dressing, and					
	personal hygie	ene. The resident had					
	no limitations t	o her upper or lower					
	extremities, ar	nd the resident had a					
	history of falls	in the last month, falls					
	in the last 2 to	6 months, has had no					
	fractures, and	has had 2 or more falls					
	with no injury s	since admission.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLET	ED
		155218	B. WIN			10/23/20	12
			B. WII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
KINDDE	TDANCITIONAL (CADE AND DELIABILITATION D	VED		REAT LAKES DR		
KINDREL	J TRANSITIONAL (CARE AND REHABILITATION-D	YEK	DYEK, I	N 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Review of the I	post fall evaluation #1,					
		indicated the resident					
	•						
	was lound on t	the floor at 12:45 a.m.					
	Review of post	t fall #2 evaluation,					
	dated 10/1/12,	indicated the IDT team					
	· ·	ved the fall. The					
		nade to consult the					
	Physician abou	•					
	_	edication) being given					
	at night.						
	Review of Phys	sician Orders, dated					
	_	indicated there was no					
	=	tivan to be given					
		_					
	routinely at hig	ht to the resident.					
	Review of the p	post fall #1, dated					
	10/14/12 at 2:0	00 a.m., indicated the					
	resident was fo	ound on the floor matt					
		d. The resident					
	sustained a SK	in tear to her left elbow.					
	Review of the p	post fall #2, dated					
	10/17/12, indic	ated IDT summary					
	review which ir	ndicated the resident					
		and was not sleeping at					
		and was not steeping at					
	night.						
		current plan of care					
	that was updat	ed on 9/4/12, indicated					
	the resident ha	nd an actual fall with					
		lated to unsteady gait.					
	• .	oproaches were to					
	continue interv	entions on the at risk					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155218	B. WIN			10/23/2012
		L	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	₹			REAT LAKES DR	
KINDDE	TDANCITIONAL (CADE AND DELIABILITATION D	VED			
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-D	YEK	DYER, I	N 46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	nlan null tah a	larm to wheelchair and				
	bed.	idili to wilcoloriali aria				
	bea.					
	Review of Phys	sician Orders, dated				
	10/23/12, indic	ated Ambien (a				
		ed for sleep) was				
		resident for insomnia.				
		resident for insomina.				
	latamile	the Device of the size				
		the Regional Interim				
	Director of Nur	rsing #1 on 10/23/12 at				
	11:17 a.m., ind	licated the resident's				
	Physician was	not notified of the				
	-	essness and insomnia				
	_	ntil 10/23/12. She				
		DT interventions should				
	have been con	npleted in a more				
	timely manner.	She further indicated				
	•	as just ordered on				
		the resident had				
	another fall on	10/14/12.				
	3.1-45(a)(2)					
			1			l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.			REAT LAKES DR		
KINDRED	O TRANSITIONAL (CARE AND REHABILITATION-DY	ΈR		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
F0325	483.25(i)						
SS=D	MAINTÁIN NUTR	RITION STATUS UNLESS					
	UNAVOIDABLE						
		ent's comprehensive					
		facility must ensure that a					
	resident -						
		eptable parameters of					
		such as body weight and less the resident's clinical					
		strates that this is not					
	possible; and	strates that this is not					
		erapeutic diet when there is					
	a nutritional probl						
	Based on obse	ervation, record review	F03	25	1. Residnt # 52 has been		11/22/2012
	and interview.	the facility failed to			discharged home. Resident		
	•	able parameters of			# 211 was referred referred to	the	
	·	maintained related to			Rd and recommendations		
	nutritional inter				implemented. Resident #34 h		
		s ordered for 1 of 1			been reviewed and interventio current with resident's	ns	
	-				preferences and nutrition		
		wed for dialysis			recommendations.2. All		
		Il as making a dietary			residents with a significant we	ght	
		significant weight loss			loss have the potential to be		
		ents reviewed for			affected. All residents weighe		
		6 who met the criteria			weekly have the potential to be		
	for nutrition. (F	Residents #34, #52,			affected. All residents with a R		
	and #211)				nutritional recommendation hat the potential to be affected. A		
					audit of all residents with a	11	
	Findings includ	le:			significant weight loss and with	า	
					RD recommendations has bee		
	1. The record	for Resident #52 was			completed for completion of		
		0/19/12 at 8:45 a.m.			re-weights if indicated the		
		an of care, dated			implementation of nutritional		
	-	ted the resident had			recommendations. 3. All nursi staff and the RD have been	ng	
	· ·				educated on obtaining weights		
	•	r weight fluctuations			and re-weights, nutritional risk		
		tic (water pill) use and			residents referral to RD and		
	_	dentures. One of the			implementing RD nutritional		
	ınterventions in	ndicated to monitor and			interventions. 4. The		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPL	ETED
		155218	A. BUII B. WIN	LDING		10/23/	2012
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
I (I) ID DE		0.00 AND DELLAR LITATION DV			REAT LAKES DR		
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-DY	EK	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	evaluate any w	veight loss, determine			DNS/Designee with the RD wi		
	•	st, and follow facility			review residents with significal	nt	
	protocol for we				weight loss, residents with		
	protocorior we	ight 1033.			re-weights for completion, and		
	Dovious of the	racidant'a waisht			implementation of RD nutrition	al	
		resident's weight			recommendations for		
	_	ed on 9/7/12, he			implementation in the weekly NAR meeting as an on going		
		ounds and on 9/13/12			practice of this facility. A week	lv	
	_	3.2 pounds. A 14.8	1		log of all residents reviewed w		
	pound loss. The	here was no re-weight			be maintained weekly. All		
	available for re	eview.			findings will be reported in the		
					monthly PI meeting and the PI		
	A Physician's o	order, dated 9/6/12,			commitee will determine if 100		
	•	esident was receiving a			compliance has been achieved		
		_			if furhter monitoring is required	i.	
	•	he only "Nutrition					
		' available for review					
		2/12, prior to the					
	resident's weig	jht loss.					
	Davidson of the c	UNA					
		"Measuring and	1				
	_	Height and Weight"					
	policy on 10/19	9/12 at 1:50 p.m., which					
	was provided b	by Regional Interim					
	Director of Nur	sing #2 and identified					
		icated the following: "If					
	,	a 5 pound or more	1				
		the most recent					
	weight, the sca						
		nd the weight taken					
	_	m accuracy. If a					
		lanned weight change					
	is identified, co	omplete a significant					
	change of state	us if appropriate."	1				
	-						
	Interview with	the East Unit Manager	1				
		2:33 p.m., indicated					
	311 13/13/12 al	2.00 p.m., maioatea	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	r í	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		PLETED
		155218	B. WIN			10/2	3/2012
NAME OF I	DDOMDED OD GUDDU IED		-	STREET A	DDRESS, CITY, STATE, ZIP COL	DE	
NAME OF F	PROVIDER OR SUPPLIER			2300 GF	REAT LAKES DR		
		CARE AND REHABILITATION-	DYER		N 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
		sually weighed weekly					
		pancy is noted, the					
	Registered Dietitian (RD) is notified and it is up to her to ask for a						
	re-weight.						
		the RD and Dietary					
		10/19/12 at 2:45 p.m.,					
	indicated they	were not aware of the					
	resident's weig	ht loss and would look					
	into it. They fu	rther indicated a					
	re-weight shou	ld be completed if					
	there was a 5 p	oound gain or loss					
	since the last w	veight.					
		-					
	The resident w	as seen by the RD the					
	evening of 10/1	19/12 and the progress					
	_	the following: "resident					
		a 11.5 pound/8.3%					
	_	ce admission. Weight					
	_	ed to be arrested.					
		t today to discuss					
		e agrees that he					
	_	veight in the hospital					
	, ,	o's to 130's, but he					
	•	that he cleans his					
		wife also brings in food					1
	T = 1	Is like there has been					
		ment since he came to					
	1	commend to start					
		with meals and weigh					
	weekly for 4 we	eeks.					
	2. On 10/17/1	2 at 9:00 a m	l				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLET	ΓED
		155218	B. WIN			10/23/20	012
NAME OF B	DDOVIDED OD CLIDDLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2300 GI	REAT LAKES DR		
KINDRE	O TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ing room. The resident					
		e waffle, a bowl of hot					
		sausage links. The					
	resident did not receive double portions of protein.						
		t 12:48 p.m., the					
		bserved eating lunch in					
		g room. The resident					
		e cup of ice cream, a					
		, a regular portion of					
	turkey a la king, seven green beans,						
	and one biscui	t.					
	0 4044044						
		t 8:07 a.m., the					
		bserved in the main					
		aiting on breakfast. At					
		was served one					
	_	mbled eggs, one piece					
		ne bowl of hot cereal.					
		id not receive double					
	portions.						
	The record for	Posident #211 was					
		Resident #211 was 0/17/12 at 8:28 a.m.					
		as admitted to the					
		/12 from the hospital.					
		diagnoses included,					
		mited to, muscle					
		iculty in walking, atrial					
		n blood pressure and					
	osteoporosis.						
	Review of Phy	sician Orders on the					
	1	ecap, indicated the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		2300 GF	REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	ÆR		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident was to	receive double					
	portions of pro	tein at every meal.					
	Review of the	resident's weights were					
	as follows:	3					
	6/20 151						
	6/24 142						
	6/25 144						
	7/8 138						
	7/10 139						
	7/10 139						
	7/23 137						
	7/30 132						
	8/1 133						
	8/8 133						
	9/5 136						
	10/2 139						
	10/4 138						
	Review of the	Registered Dietitian					
		notes, dated 6/28/12,					
	ı , , . •						
		esident weighed 142					
	•	reweigh of 144, which					
		weight loss over 30					
	•	ident's weight loss was					
	•	I undesirable. The RD					
		dmit weight may have					
	been incorrect	and will continue					
	weekly weights	s to ensure accuracy.					
	Another RD pr	ogress note, dated					
	7/11/12, indica	ted the resident					
	-	ounds and had been					
		e for three weeks.					
	, , , , , , , , , , , , , , , , , , , ,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL 10/23/	ETED	
		100210	B. WIN			10/23/	ZU 1Z
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RINIDDE	TDANICITIONAL 4	ONDE AND DELIADII ITATIONI DV	ED		REAT LAKES DR		
		CARE AND REHABILITATION-DY	ĽK.	<u> </u>	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAU		dietary progress note,	+	IAU			DATE
	dated 7/26/12,						
	recommendation by the Registered Dietitian was to serve the resident						
		s of protein at all					
	meals.	1					
	Review of the	current plan of care					
		indicated the resident					
	was at nutrition	nal risk related to					
	mechanically a	ltered diet and					
	thickened liquid	ds. The Nursing					
		ere monitor daily					
	•	or for diet texture,					
	_	s, and provide diet as					
	ordered.						
	Intonvious with t	the Dieton, Food					
		the Dietary Food					
	_	0/18/12 at 8:40 a.m., as not aware that the					
		o receive double					
		tein at all meals.					
	portions of pro-	tom at an moals.					
	3. On 10/18/12	2 at 1:55 p.m., Resident					
		ved seated in a geri					
		t of the Nurses' station.					
		ofoam container on her					
	•	dicated she had tacos					
	•	indicated at that time,					
	that she goes t	to dialysis every					
	Tuesday, Thur	sday, and Saturday.					
	She further ind	licated they pick her up					
	around 5:00 a.	m., and she returns to					
	the facility betv	veen 10:00 and 10:30					
	a.m.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.			REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	served her breareceived extra She indicated to and she was not resident was the Nepro supplindicated only at the facility. She like the supplet The record for reviewed on 10 The resident we facility on 7/30/Prior to her host residing in anot facility. The resident's but were not liminated in the facility on 7/30/Prior to her host residing in anot facility. The resident's but were not liminated in the facility of Physical services of Physical forms and hyperiod increase protein was sent to the admit on 9/14/Friendler.	a bed where she was akfast meal. She bacon, and pancakes. The bacon was burned of going to eat it. The nen asked if she gets blement and she at dialysis and not at e indicated she did not					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155218	B. WIN	G		10/23/2012	
NAME OF P	ROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					REAT LAKES DR		
KINDRED	O TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	-	indicated to add					
	•	at all meals. Another					
	Physician Order, dated 8/3/12, indicated Nepro vitamin and Nepro						
	eight ounces to	wice a day.					
	The week denoted	Arrange of to the feetility as					
		eturned to the facility on					
		ew of Physician Orders					
		dicated the Nepro					
		as not reordered. It					
	was not on the						
		Record, and there was					
		tion the resident was					
	receiving the N	lepro at the facility.					
	There was no	documentation the RD					
		the resident for the low					
	albumin level i						
		d October 2012.					
	September and	d October 2012.					
	The PD was at	t the facility on 9/17,					
		6, 10/7, and 10/12/12.					
		ech was at the facility					
	•	9/25, 9/26, 10/3, 10/5,					
	10/10, and 10/						
	10/10, and 10/	14114.					
	Review of the	RD progress note,					
		indicated the resident					
	-	ain of seven pounds.					
		ad adequate intakes					
		ving a multivitamin and					
		e RD addressed the					
		ent lab work from the					
	hospital and m						
	recommendation						
	i recommendado	una.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вит	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Center RD, da the resident's and she wante continue the p be provided hi Interview with 11:13 a.m., inc the resident ar 10/7 and did n recommendati the Nepro sup indicated that or interviewed on that day sh center. The R resident did not facility's food, the resident di supplement. The RD furthe not spoken to starting at the further indicate	on for her to continue plement. She further she had not spoken to the resident because e was at the dialysis. D was unaware the ot always eat the and she was unaware d not like the Nepro r indicated that she had the dialysis RD since facility in 9/12. She ed she was unaware of from the Dialysis					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			В. WП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		l	GREAT LAKES DR		
KINIDREI	TRANSITIONAL (CARE AND REHABILITATION-DY			IN 46311		
	THANOITIONAL	SAKE AND KENADIEN ANON-DI	LIX	DILIX,			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0363	483.35(c)						
SS=C		RES NEEDS/PREP IN					
	ADVANCE/FOLL						
	residents in accor	et the nutritional needs of					
		etary allowances of the					
		on Board of the National					
		il, National Academy of					
		pared in advance; and be					
	followed.	•					
	Based on obse	ervation, record review	F03	63	1. 130 Residents had the		11/22/2012
		, the facility failed to			potential to be affected. The		
		u as prepared in			dietary manger was provided		
		e Registered Dietitian.			written counseling. A new die		
	•	<u> </u>			manger will start on 11/26/201		
	•	otential to effect 130			2. Of the 130 residents with the	те	
		e 136 residents who			potential to be affected no	_	
	resided in the f	acility.			adverse affect was noted. The Dietary staff and dietary mana		
					have been in-serviced on	gei	
	Findings includ	le:			following menus, reviewing		
					spreadsheets before the meal	aff	
	On 10/15/12 at	t 12:15 p.m., the West			on the tray line and having		
		m was served lunch.			spreadsheets available to st a	nd	
	_	who received regular			posting substitutions.3.		
		<u> </u>			In-serving with all dietary		
	_	en baked beans. No			employees on Menus,		
	resident receiv	ed sauerkraut.			spreadsheets, portion		
					sizes, Production pull carts will done the day before, and	ı be	
	The menu post	ted outside the dining			Substitutions has been		
	room indicated	the residents were to			completed. 4. The DM/Dietar	v	
	receive sauerk	raut.			consultant will audit the trays f	-	
					accuracy with following menus		
	On 10/17/12 in	the Main dining room,			and posting substitutions twice		
		th meal, the residents			daily X 5 days a week X 3 mor		
	•	regular diet, were			then weekly X 3 months. All		
					findings will be reported in the		
	~	eans. No residents			monthly PI meeting and the PI		
	received peas.				committee will determine if 100		
					compliance has been achieved		
					if furhter monitoring is required	J.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155218	B. WIN			10/23/2012	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		2300 GF	REAT LAKES DR		
KINDRE	TRANSITIONAL (CARE AND REHABILITATION-D	YER		N 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	The menu pos	ted outside of the					
	dining room ind	dicated the vegetable					
	to be served w						
	On 10/17/12 di	uring the noon meal,					
		on the East unit					
		wedish meatballs.					
		ervation on 10/17/12 at					
		licated the residents in					
	-	g room were served					
	,	e residents in the Main					
	Swedish meat	ere served three					
	Swedish meati	oalis.					
	Dovious of the	current menu and					
		for Monday, week two,					
		esidents were to					
	receive sauerk	raut.					
	Review of the	menu and					
		for Wednesday, week					
		the residents were to					
	·	nd not green beans.					
	i receive peas a	ina not green beans.					
	Review of the	spreadsheet for a					
		Thursday, week two,					
	_	esidents were to					
	receive 3 meat						
	i receive o illeai	wans.					
	Interview with	the Dietary Food					
		•					
	_	0/17/12 at 1:03 p.m.,					
		nenu was not changed					
	_	room to reflect what he					
		d. He further indicated					
	he did not have	e enough sauerkraut					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IDENTIFICATION NUMBER: 155218	A. BU	MULTIPLE CO JILDING	00	COM	PLETED 3/2012
PROVIDER OR SUPPLIER	L CARE AND REHABILITATION-D		STREET A	DDRESS, CITY, STATE, ZIF REAT LAKES DR IN 46311	P CODE	
SUMMARY S (EACH DEFICIEN REGULATORY OR for everyone of not have peas Wednesday. Interview with I 10/18/12 at 1:0 had thought the	CARE AND REHABILITATION-DY TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) n Monday and he did	YER	STREET A		ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE

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Facility ID: 000123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155218	B. WIN			10/23/	2012
NAME OF B	DOLUBED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIER			2300 GI	REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DY	ΞR	DYER, I	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0368 SS=C	483.35(f) FREQUENCY OF BEDTIME Each resident recoprovides at least of regular times commealtimes in the commealtime in the commeant in the c	every served on dents in the Main the South, and West This had the potential exidents of the 136 resided in the facility.	F03		1. 130 residents had the potento be affected. No adverse affected. No adverse affected was noted. All meal times have been posted within the 14 hou timeframe. 2. 130 Residents have been posted within the potential to be affected. No adverse affects was noted from meals served not served timely Meal times have been posted all dining rooms. Department managers have a dining room assignment to monitor timeline in serving meals daily. The Dietary manager was counsel and a new Dietary Manager was start on 11/26/2012.3. In-servicing has been complete with nursing staff, department	ect re ad o m y. in	11/22/2012
	and were place At 12:15 p.m., t	ed in the Dining Room. the staff were			heads and dietary staff on ensuring meals are served on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIT	ILDING	00	COMPLE	TED
		155218	B. WII			10/23/2	012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ı	
NAME OF P	PROVIDER OR SUPPLIER	L.			REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ss the first tray from			time.4. The DM/Dietary		
	the first cart.				consultant will audit meal serv daily x 5 days a week for 1	ice	
					month, then twice weekly x 1		
	On 10/15/12 at	: 12:25 p.m., the first			month then weekly for 4 month	hs.	
	cart of lunch tra	ays arrived to the			A log will be maintained by		
		e second cart arrived			department managers of meal		
		2:30 p.m. At that time,			start time daily X 3 months. A		
	the trays were	•			findings will be reported in the		
	residents.	p			monthly PI meeting and the P commitee will determine if 100		
	. 55.45.116.				compliance has been achieve		
	On 10/15/12 at	: 12:38 p.m., the Main			if furhter monitoring is required		
		/as served lunch.			3 : 4		
		vas serveu iuricii.					
	On 10/16/12 at	: 8:50 a.m., the Main					
		•					
		vas served breakfast.					
	Op 10/17/12 of	9:40 a m the Main					
		8:40 a.m., the Main					
	Diffing Room w	vas served breakfast.					
	On 10/18/12 at	: 8:15 a.m., the West					
		m just started to pass					
		trays. At that time, the					
		om announced they					
		serve breakfast.					
	CNA #6 indicat	ted at that time, that					
		sidents to get up and					
		to go down to the					
	1	~					
	dining room to	μαδο παγδ.					
	Interview with t	he Consultant Dietitian					
		8:27 a.m., indicated					
		,					
		ff were ready to serve					
		vever, they needed to					
	∣ wait on the We	st Unit CNA's to come					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	R			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-DY	′ER		IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and pass trays	in the Main Dining					
	Room.						
	Review of the	meal times posted					
	outside of the Main Dining Room						
		kfast was to be served					
		nd lunch at 12:30 p.m.					
	at o. 10 a.iii., a	na ianon at 12.00 p.m.					
	The South Uni	t dining room was to be					
	served breakfa	ast at 8:00 a.m. and					
	lunch was sch	eduled for 12:20 p.m.					
		•					
	The West Unit	dining room was to be					
		ast at 7:35 a.m. and					
		eduled for 12:00 p.m.					
	lunch was som	eduled for 12:00 p.m.					
	Interview with	the Dietary Food					
		0/18/12 at 8:40 a.m.,					
	_						
		reakfast time posted in					
	the Main Dinin	g Room was 8:15 a.m.					
	0.4.04(=)						
	3.1-21(c)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CC LDING	ONSTRUCTION 00	(X3) DATE : COMPL	ETED
	155218	B. WIN			10/23/	2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHABILITATION-DY	ER	2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store or serve food under sanitary conditions related to glove usage, hair restraints, dirty oven racks and uncovered and not labeled food for 1 of 1 kitchens. This had the potential to effect 130 residents of the 136 residents who resided in the facility. (The Main Kitchen) Findings include: 1. During the Brief Kitchen Sanitation Tour on 10/15/12 at 9:34 a.m., the following was observed: A. There were 12 individual servings of cottage cheese in plastic dishes located in the reach-in cooler that had no date. There were two individual servings of yogurt in plastic containers that had no date on them. There were 18 individual servings of applesauce containers that were uncovered and had no date on them.	F03	71	1. 130 residents had no adve affects. The dietary manger destroyed the items in the rea in that had no date on them. Dietary Cook #1 has been in-serviced on sanitary conditi related to glove use and using utensils, the two convection ovens were cleaned and the maintenance supervisor completed PI for hair restraint 130 residents had the potentia be affected. All items in the re in have been covered and dat the dietary cook has PI regard sanitary conditions, the maintenance supervisor has hPI for Hair restraints, the oven have been cleaned and will be a daily (light) and weekly (through) cleaning schedule. new dietary manager starts 11/26/2012.3. In-servicing wit dietary staff on Food and Sup Storage with emphasis on labeling food with a "use by date" and covering items in the reach in, Principles of Safe For Handling with emphasis on sanitary conditions related to glove use and using utensils, Kitchen cleaning schedule and use of hair restraints in the	ch The ons I s.2. al to ach ed, ling had s e on The ch ply de	11/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155218	- 1			10/23/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R			REAT LAKES DR	
KINIDDEL	TDANGITIONAL (CARE AND REHABILITATION-D	VED		IN 46311	
KINDKEL	J TRANSITIONAL I	CARE AND REHABILITATION-L	/ I EIX	DIEK,	111 40311	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	None of the ab	oove items were dated			kitchen.4. The Dietary Manag Dietary consultant will comple	
	or had lids to indicate a "use by" date.			le a		
	There were thr	ree packages of yogurt			Nutrition Services "Quick Rounds" audit daily x 5 days a	,
	floating in water	er with some ice cubes			week for 3 months and then	
	in a metal cont	tainer.			weekly for 3 months. The ED	will
					complete a Nutrition Services	
	Interview with	the Dietary Food			"Quick Round" audit weekly fo	r 3
		e time, indicated the			months. All findings will be	
	_	ms should have been			addressed and corrected	ngo
	covered and labeled with a date.				immediately and then, All findi will be reported in the monthly	
					meeting and the PI commitee	
	0. Danis a Har F				determine if 100% compliance	
	_	During the Full Kitchen Sanitation			has been achieved or if furhte	
		/12 at 11:06 a.m., the			monitoring is required.	
	following was	observed:				
	A. Dietary Cod	ok #1 was observed				
	preparing the r	noon meal. At that				
	time, he was o	bserved taking food				
	temperatures.	After taking the food				
	•	the cook removed his				
	•	ew them away. He				
	_	ew gloves on both of his				
	•	not wash his hands				
		water or use an alcohol				
	•					
	•	tarted to prepare the				
	residents' mea	ıı trays.				
	l _					
		observed preparing the				
	' ' '	picking up a couple of				
	pieces of raw f	resh spinach with his				
	gloved hands a	and placing it on the				
	plates. He did	not use utensils to do				
	this. He then placed one piece of					
	•	•				
	this. He then peggplant parm					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	A. BUI	LDING	NSTRUCTION 00	COM	E SURVEY PLETED 23/2012
		133210	B. WIN				.5/2012
NAME OF P	PROVIDER OR SUPPLIEI	3			DDRESS, CITY, STATE, ZIP CO	DE	
KINIDDE		CARE AND RELIABILITATION F	WED		REAT LAKES DR		
KINDREL	J TRANSITIONAL	CARE AND REHABILITATION-D	TER	DYER, I	N 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	I	e by touching it with his					
	•	and placing it on the					
	l •	also observed touching					
	the plates, oth	er utensils, the front of					
	· ·	picking up a towel to					
	wipe off the co	unter tops with his					
	gloved hands t	that he had touched the					
	eggplant and t	he raw fresh spinach					
	with. The cool	k served 12 plates					
	before the Die	tary Food Manager was					
	informed.						
	Interview with	the Dietary Food					
	Manager at the	e time, indicated the					
		e using utensils to pick					
		d to scrape it onto the					
	•	es and not his gloved					
	hands.	oo ana not mo giovoa					
	nanao.						
	B The two co	nvection ovens were					
		a heavy accumulation					
		burned food on the					
	. •						
		as on the oven racks					
	i and on the bot	tom of both ovens.					
	O D	was that					
	C. During the t						
	Maintenance S	•					
		nter the kitchen and					
	I	ly around the steam					
		hair restraint on his					
	head.						
	3.1-21(i)(3)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
		155218	A. BUII			10/23/	2012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REAT LAKES DR		
KINDRED	TRANSITIONAL (CARE AND REHABILITATION-DY	ΞR		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0412 SS=D	483.55(b) ROUTINE/EMER SERVICES IN NF The nursing facilit from an outside re with §483.75(h) of extent covered ur emergency dental needs of each resident and by arranging from the dentist's refer residents wit dentures to a dent Based on obset and interview, the ensure dental of provided for 2 of for dental servi	GENCY DENTAL TS Ty must provide or obtain resource, in accordance of this part, routine (to the resources to meet the resident; must, if necessary, rest in making appointments; for transportation to and rest office; and must promptly th lost or damaged rest tist. Tryation, record review the facility failed to revaluations were of 2 residents reviewed resources with broken and/or	F04		1. Resident has been seen by dentist for his missing partial denture. Resident #62 has a dental services apointment scheduled.2. All residents needing a dental evaluation has	, a	11/22/2012
	_	·			the potential to be affected. A audit of all residents for dental services has been completed any resident needing dental services scheduled an evaluat with the consent of the resider and responsible party.3. All	and	
	10/17/12 at 8:1 Unit dining room	7 was observed on 4 a.m., in the South m. The resident had on his upper mouth.			nursing staff and department managers have been educated on dental services.4. The DNS/Designee will audit all admissions and readmissions indication on the initial nursing	for	
	10/15/12 at 1:4 resident's partiamissing. The record for	he resident's wife on 8 p.m., indicated the al plate on the top was Resident #57 was			assessmnet for dental services as an on going practice of this facility. The DNS and SSD will monitor reports or greivances reports of missing dental appartus and follow thru with dental services if indicated as ongoing practice of this facility	ll for an	
	reviewed on 10	0/17/12 at 8:47 a.m.			The SSD will keep maintain a		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDDIC	00	COMPL	ETED
		155218		LDING		10/23/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDER		CARE AND DELIABILITATION DV	-D		REAT LAKES DR		
KINDKEL	J TRANSITIONAL (CARE AND REHABILITATION-DY	=K	DYEK,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The resident ha	ad diagnoses that			of residents needing dental		
	included, but w	vere not limited to,			services, when evaluation of		
	diabetes, deme	entia and Parkinson's			service is to be completed and		
	disease.				results of evaluation. All logs		
	3.00300.		1		and findings will be reported in the monthly PI meeting and the		
	There was no	dental evaluation noted			commitee will determine if 100		
			1		compliance has been achieved		
	in the resident'	s record.			if furhter monitoring is required		
	There was a fo	orm signed by the					
		and dated 1/16/12,	1				
		the resident could be					
	seen by the fac						
	seen by the lac	cility deriust.					
	There was a pl	hysician order, dated					
	6/11/12, that in	ndicated, "Change diet					
	•	ue to) dental status."					
	• •	written by the Speech					
	Therapist.	written by the opecen					
	тпетарізі.						
	A form titled "T	herapy Screen" that					
	was dated 6/11	1/12, and signed by the					
	Speech Therag	pist was reviewed. It					
		nsg (nursing) pt's					
		tures missing at this					
	, ,	creased cognitive					
		•					
		rall generalized	1				
		ee diet is reasonable at					
		dentures are found or					
	l '	nder the Comment					
		vife is in agreement					
	with decision to	o change diet to puree					
	at this time. Sk	illed ST (speech					
	therapy) not re	quired to treat pt at this					
	time."	•					
	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	<i>'</i>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155218	B. WIN			10/23/2012	
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(.	X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMP	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		TE
	Interview with	the South Unit Manager					
	on 10/17/12 at	10:45 a.m., indicated					
		the resident had a					
		denture. She indicated					
		erapist was asked to					
	•	esident and make a					
		on for the appropriate					
		ated the Speech					
	•	ated the resident would					
		pureed diet. The South					
		ndicated the Social					
	Service staff w	as responsible for					
	setting up dent	tal services for the					
	residents.						
	Interview with	Social Service Staff #1					
	on 10/17/12 at	10:37 a.m., indicated					
		ware that the resident's					
		was missing. She					
	•	vas responsible for					
		rrals to the Dentist. She					
		vife signed a consent					
		t to be seen by the					
	dentist on 1/16						
		was no dental					
	assessment co	empleted by a dentist in					
	the resident's r	ecord. She indicated					
	the resident sh	ould have been					
	evaluated by the	ne Dentist when the					
	partial denture						
		Ü					
	2. Resident #6	2 was observed on					
		34 a.m. The resident					
		chair and her mouth					
	i was open. The	ere was a broken tooth					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155218	B. WII			10/23/2012
NAME OF P	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE	
KINDDE	TDANIOITIONIA:	OADE AND DELIABILITATION S	WED.		REAT LAKES DR	
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER, I	N 46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ortion of her mouth, the				
		outh were discolored				
	and were in po	or condition.				
		Resident #62 was				
		0/18/12 at 2:08 p.m.				
		ad diagnoses that				
	· ·	vere not limited to,				
	dementia, hype	ertension and				
	depression.					
		utritional Assessment,				
		that indicated the				
		ed pureed food and				
		ed liquids. It also				
		e "Oral Health" section				
		nt had "caries and				
	decay."					
		UD (C. CAL)				
		"Patient Nursing				
		t 3," dated 9/11/12,				
		It indicated the				
		nissing teeth" and				
	"caries/decay."	•				
		dental evaluation in the				
	resident's reco	rd.				
		D				
		are Plan initiated on				
		dicated, "res (resident)				
	1	hospice services. Res				
		dically related services.				
		s, podiatry services,				
		, and audiology				
	services. One	of the interventions				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	
		155218	A. BUI			10/23/	2012
	PROVIDER OR SUPPLIER	CARE AND REHABILITATION-DY	ER	2300 GF	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	physician, obtaservices, arrannecessary documentation family did not viseen by the facindicated theres.	Social Service Staff #1 2:15 p.m., indicated ad not been seen by a dmission on 12/27/11. there was no that indicated the want the resident to be cility dentist. She should be a consent the family desires					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	of correction	155218		LDING		10/23/	
		133210	B. WIN			10/23/	2012
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDEL	TDANGITIONAL (CARE AND REHABILITATION-DY	ED		GREAT LAKES DR IN 46311		
KINDREL	TRANSITIONAL	CARE AND REHABILITATION-DY	EK	DIEK,	IIN 403 I I		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0428 SS=E	483.60(c)	I REVIEW, REPORT					
33-E	IRREGULAR, AC	•					
		n of each resident must be					
		once a month by a					
	licensed pharmac	cist.					
	The pharmanist m	aust report any					
	The pharmacist n	e attending physician, and					
		rsing, and these reports					
	must be acted up						
	Based on recor	rd review and interview	F04	28	1. Resident #62, 83, 168, and		11/22/2012
	the facility faile	d to ensure the			165 have had pharmacy		
	pharmacist's re	ecommendations were			recommendations acted upon	.2.	
	acted upon in a	a timely manner for 4 of			All resident's with a pharmacy recommendation have the		
	10 residents re	viewed for			potential to be affected. All		
	unnecessary m	nedications.			pharmacy recommendations f	or	
	(Resident's #62	2, #83, #168 and #165)			the past 6 months have been		
	•				reviewed and acted upon if		
	Findings includ	le:			necessary. 3. All nursing staff have been educated on		
	•				Pharmacy Recommendations		
	1. The record	for Resident #165 was			and the process for		
	reviewed on 10	0/18/12 at 10:02 a.m.			implementation.4. The		
	The resident w	as admitted to the			DNS/Designee will review the		
		12. The resident's			monthly pharmacy recommendations within one		
	•	uded, but were not			week after sending to the MD/	NP	
	•	ocarditis, muscle			for timely follow up and		
	· ·	nal stenosis, chronic			implementations. This will be		
	•	, chronic airway			on going practice monthly of the	ne	
	•	ngestive heart failure,			facility. All findings will be reported in the monthly PI		
		teoporosis, high blood			meeting and the PI commitee	will	
		e edema of the lung,			determine if 100% compliance		
	•	iency, hyponatremia,			has been achieved or if furhte	r	
		ection, anxiety state,			monitoring is required.		
	•	order, hyperlipidemia,					
	and anemia.	c. cc., my pointplacinia,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIΠ	LDING	00	COMPL	ETED
		155218	B. WIN			10/23/	2012
			J. ,, 11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	₹			REAT LAKES DR		
KINDREI	O TRANSITIONAL	CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	sician Orders on the					
		ecap, indicated the					
	resident receiv	•					
	medication use	ed to treat					
	gastroesophag	geal reflux) and Astelin					
	(an anti-histam	nine) Nasal Spray.					
	Review of the	Pharmacist					
	recommendati	on, dated 4/20/12,					
		ase provide diagnoses					
		routine use of Protonix					
	and Astelin Na						
	Interview with	the District Director of					
		tions on 10/19/12 at					
		licated they had just					
		sician to obtain the					
		the Protonix and the					
		She further indicated					
		diagnoses in the					
		for the use of those two					
	medications.	5 Did					
		for Resident #168 was					
		0/19/12 at 12:19 p.m.					
		ad diagnoses that					
	·	vere not limited to,					
		niplegia, depression					
	and aphasia (d	lifficulty with speech).					
	There was a fo	orm titled "Note to					
	Attending Phys	sician/Prescriber" that					
		sident receives Celexa					
	·	ssant) 20 milligrams					
	1 '	day). Regulations					
	` • / · ` `	ual dose reduction					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155218		ILDING	00	COMPL 10/23/	
		100210	B. WIN		DDBECC CITY CTATE ZB CODE	10/23/	<u>-</u> J 12
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		N 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	,				CROSS-REFERENCED TO THE APPROPRI	ATE	
PREFIX TAG	attempt unless contraindicated dosage reducti document why appropriate." T 5/22/12 and was Pharmacist. Review of the r was no evidence was notified of recommendation evidence that t responded to the substitution of the resident has included, but we dementia, mac seizures. There was a for Attending Physical attending Physical dosage reduction attending the substitution of the resident has included, but we dementia, mac seizures.	clinically d. Please consider a on at this time or this may not be the form was dated as signed by the record indicated there be that the Physician the Pharmacist's on and there was no the physician the recommendation. or Resident #62 was 0/18/12 at 2:08 p.m. ad diagnoses that were not limited to, ular degeneration and orm titled "Note to sician/Prescribe" that		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION DATE
	•	Ild you please provide the following routine) Ropinirole (a					
		ed for restless leg					
	l *	rilosec (a medication					
	was dated 4/19	cid reflux)?" The form 9/12 and signed by the					
	Pharmacist.						
		ther form titled "Note					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155218		ILDING	00	10/23/2	
		100210	B. WIN		DDDEGG CITY CTATE ZID CODE	10/20/2	2012
NAME OF I	NAME OF PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DR		
KINDREI	D TRANSITIONAL	CARE AND REHABILITATION-D	YER	1	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL B. L.S.C. IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION) esident receives Lexapro		IAG			DATE
		ssant medication) 10 mg					
		ry evening). Regulations					
	,	age reduction attempt					
		e first year unless it is					
		raindicated. Please					
		sage reduction at this					
		nent why this may not be					
	appropriate. T	he form was dated					
	6/25/12 and w	as signed by the					
	Pharmacist.						
		Note to Attending					
		scribe" that indicated,					
		eives Enablex (a					
	medication us						
		dder) and Ropinirole. ase provide a diagnosis					
		ir use." The form was					
		and signed by the					
	Pharmacist.	and digned by the					
	- Hamildoloti						
	Review of the	record indicated there					
	was no evider	nce the Physician was					
	notified of the	Pharmacist's					
	recommendat	ions. There was no					
	evidence the I	Physician responded to					
	the recommer	ndations.					
		for Decident #00					
		for Resident #83 was					
		0/17/12 at 1:13 p.m.					
		nad diagnoses that					
		were not limited to,					
	1	chorea, dysphagia					
	(difficulty swal	nowing) and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155218	B. WIN			10/23/2	2012
		L	b. Wil		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
KINDDE		CADE AND DELIABILITATION D	VED		REAT LAKES DR		
KINDREL	TRANSITIONAL	CARE AND REHABILITATION-D	YEK	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hypertension.						
	, p o. to						
	Th	4:411 UNI - 4 -					
		orm titled "Note to					
	Attending Phys	sician/Prescribe" that					
	indicated, "Cou	uld you please provide					
	a diagnosis to	support the routine use					
		allergy medication)?"					
		dated 4/20/12 and					
	signed by the F	rnarmacist.					
	Review of the	record, indicated there					
	was no eviden	ce that the Physician					
	was notified of	the Pharmacist					
		ons and there was no					
	evidence that t	-					
	responded to t	he recommendation.					
	The policy title	d, "Pharmacist					
	Consultation" r	provided by Minimum					
	-	S) Coordinator #2, on					
	•	reviewed. She indicated					
	the policy was	current.					
	The policy indi	cated "The pharmacist					
	conducts mont	thly medication regimen					
). The results of the					
	, ,	ocumented by the					
		•					
		ne MRR is a part of					
	•	clinical record. If					
	documentation	of the findings was not					
	in the active re	cord, it was maintained					
		er and readily available					
	for review.	c. and readily available					
	IOI ICVIEW.						
	T I D I (
	The Director of	f Nursing and the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
ANDILAN	OI CORRECTION	155218		LDING		10/23/	
		.552.5	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-DY	ER		IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	• • •	ician act on the					
	•	eview by: A.) For those					
		uired physician e physician either					
		cts upon the report and					
	•	nmendation, or B.)					
	•	some of the report and					
	_	of explanation of why					
	-	dation is rejected such					
	as a dated pro	gress note."					
		the Director of Nursing					
	on 10/18/12, in						
	•	as for the facility and					
	•	o respond to the					
		eview within 7 days.					
		there was no evidence s records that the					
		re notified of the					
	_	ecommendations. She					
		there was no evidence					
		cians acted upon the					
	recommendation	•					
	3.1-25(j)						
			1				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155218	A. BUII			10/23/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINDDEE		CARE AND DELIABILITATION DV	-D		REAT LAKES DR		
KINDREL	TRANSITIONAL (CARE AND REHABILITATION-DY	EK	DYEK,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=D		NTROL, PREVENT					
	SPREAD, LINEN						
		establish and maintain an					
		Program designed to					
		anitary and comfortable					
		to help prevent the I transmission of disease					
	and infection.	i ilaliəliliəsidli di ülsedse					
	and micodon.						
	(a) Infection Cont	trol Program					
	` '	establish an Infection					
	Control Program						
	(1) Investigates, of	controls, and prevents					
	infections in the fa						
		procedures, such as					
		be applied to an individual					
	resident; and						
		ecord of incidents and					
	corrective actions	s related to infections.					
	(b) Preventing Sp	oread of Infection					
		ection Control Program					
		a resident needs isolation to					
		ad of infection, the facility					
	must isolate the r						
		ust prohibit employees with					
		disease or infected skin					
	lesions from direct	ct contact with residents or					
		ct contact will transmit the					
	disease.						
		ust require staff to wash					
		each direct resident contact					
		ashing is indicated by					
	accepted profess	nonai practice.					
	(c) Linens						
	• •	nandle, store, process and					
		so as to prevent the spread					
	of infection.						
	Based on obse	ervation, record review,	F04	41	1. Resident # 184 has had no		11/22/2012
		the facility failed to			adverse effect. LPN #5 has be		-

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	д ріп	LDING	00	COMPLE	TED
155218 A. BUILDING B. WING			10/23/2012				
		1			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR		
		CARE AND REHABILITATION-DY	ER	DYER,	IN 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
		censed staff member			educated on Hand Hygiene/Hawashing.2. All residents recei		
		ands after touching a			medications from LPN #5 had		
	_	medication pass for 1			potential to be affected. LPN #		
		taff members observed			has been educated on Hand		
	_	tion pass. (Resident			Hygiene/Hand washing.3.		
	#184)				Education has been complete	d	
	Findings include:				with all employees on Hand Hygiene with emphasis on har washing.4. The DNS/Designe will complete infection control		
	On 10/19/12 at	t 5:18 a.m., LPN #5			rounds with emphasis on hand	,	
		preparing Resident			washing weekly for 3 months,	1	
		tion. The LPN crushed			then monthly for 3 months.All		
					findings will be addressed		
		medication and placed			immediately. All findings will b	е	
	· ·	ig. She then opened a			reported in the monthly PI	النب	
		h (a patch to control			meeting and the PI commitee determine if 100% compliance		
	pain). The LPI				has been achieved or if furthe		
		d pressure with her			monitoring is required.		
		nd then gave him his					
		he LPN then removed					
		old Lidoderm patch on					
	his back with h	er bare hands and					
	placed the new	•					
	resident's back	with her bare hands.					
	She then left th	ne room and pushed					
	her cart to the	Nurses' station. The					
	LPN then proc	eeded to sign out the					
	•	ications in the book					
		ther items on her cart.					
		ed behind the Nurses'					
		down to finish other					
		he LPN did not use					
		wash her hands with					
	_						
	-	r before leaving the					
	resident's roon	1.					
			1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER				INSTRUCTION 00	(X3) DATE COMPL			
155218			A. BUILDING B. WING 10/23/2012					
NAME OF D	ROVIDER OR SUPPLIEF		p. ,,		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
			2300 GREAT LAKES DR					
KINDREI	TRANSITIONAL (CARE AND REHABILITATION-DY	ER	DYER, I	IN 46311			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
1710		current 8/11 "Hand		mo	·		DATE	
		washing" policy						
		e South Unit Manager,						
	•	Hygiene was to be						
	performed afte	r touching bare parts of						
		than clean hands and						
	•	d portions of arms.						
		vith a patient's intact						
	, ,	n taking a pulse or e and lifting a patient).						
	biood pressure	e and illung a patient).						
	Interview with t	the LPN at the time,						
		did not wash her hands						
		hol gel before leaving						
	the resident's r	•						
		the South Unit Manager						
		10:55 a.m., indicated						
		ald have washed her						
		ap and water or used						
	alconol gel bel	ore leaving room.						
	3.1-18(I)							
	0.1 .0(.)							
			1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155218				10/23/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					REAT LAKES DR		
KINDREL) TRANSITIONAL (CARE AND REHABILITATION-DY	=R	DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0465	483.70(h)						
SS=F	SAFE/FUNCTION	NAL/SANITARY/COMFOR					
	TABLE ENVIRON	N					
		provide a safe, functional,					
	-	nfortable environment for					
	residents, staff ar	-					
	Based on obse	ervation and interview,	F04	65	The two heating units in the		11/22/2012
	the facility faile	d to ensure the kitchen			South Dining room are repaire	d	
	was clean relat	ted to dirty wall tile,			and attached to the wall		
		C pipes, dirty ceiling			properly. All areas in room 9 a		
	_	t wheels, and dirty			room 15 on the south unit have		
					been cleaned and replaced or		
		The facility also failed			repaired. All residents residing the south unit had no adverse	on	
		esidents' environment			affect. Staff working the South unit had no adverse affect. The cracked tiles in the West Unit Dining room have been replaced.		
	was clean and	in good repair related					
	to stained floor	tile, marred walls,					
	marred floors,	cracked floor tile, and					
		ot attached to the walls			The entertainment center has		
	_	en areas and for 2 of 3			the edging replaced.		
		nin Kitchen, West Unit,			The laminate edging in the par	ntry	
	•				has been replaced. The cove		
		t). This had the			base in the men's shower roor		
	•	ect 136 residents who			has been repliced. In rooms 1		
	resided in the f	acility.			102, 107, 112, 113, and 132 th	ne	
					marred walls, scuffed floors,		
	Findings includ	le:			green stains on the bathroom		
					faucet, cracked floor tiles, stail in bathrooms, dirt and dust ha		
	1 During the F	Brief Kitchen Sanitation			been cleaned or repired. The	v G	
	_	12 at 9:34 a.m., the			walls with two paint colors hav	e	
		•			been painted one colorand the		
	following was o	buserved:			closet door in room 132		
					replaced.The dietary and		
		e disposal in the dish			maintenance staff initiated		
	room was rusty	/, dirty and had peeling			cleaning immediately in the		
	paint.				kitchen on the following items:		
	•				wall tile, PVC pipes, ceiling ve		
	B The lower w	vhite wall tile was dirty			transportation cart wheels and		
					garbage cans and all items		
	•	tered all along the walls			placed on a cleaning schedule		
	in the dish room. The beige plastic		1		71 residents residing on the w	est	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER:	A DIJI	DINC	00	COMPL	ETED	
	155218		A. BUILDING B. WING				10/23/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			REAT LAKES DR			
KINIDDEI	TDANCITIONAL (CARE AND REHABILITATION-DY	ED		IN 46311			
KINDKEI	J TRANSITIONAL (CARE AND REHABILITATION-DT		DIEK,	111 463 1 1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	lower back spla	ash was also dirty with			unit had the potential to be			
	food splattered	l all over it.			affected. No adverse affect ha			
	·				been noted. All areas of conc	_		
	C The ceiling	in the dish room was			identified have been cleaned o	or		
	food stained th				repaired. All staff have been in-serviced on Maintenance sli	ine		
		noughout.			and communication. The kitch	•		
	D Thems	hua kaanan ankati			is cleaning dirty wall tile, dirty			
		two transportation			PVC pipes, dirty ceiling vents,			
	carts that were	e dirty.			dirty cart wheels and dirty			
					garbage cans.3. In-servicing h	as		
	E. The floor di	rain located under the			been completed with			
	dish machine v	vas dirty with adhered			housekeeping, dietary, and			
		he white PVC pipes by			maintenance on General			
		r the dish machine			Environmental Conditions,			
	were dirty and				Patient's Environment, Kitcher	ו		
	were unity and	stanieu.			and housekeeping cleaning schedule. 4. The ED/Designe	•		
					will complete center rounds,	Е		
		two ceiling vents that			review greivances related to			
		a heavy accumulation			environment and maintenance	;		
	of dirt and dust	t.			slips twice weekly x 3months,			
					then weekly x 3 months to			
	H. The tan gar	rbage can by the hand			evaluate the effectiveness of			
	washing sink w	vas observed with food			interventions implemented and			
	_	dirt noted on the			monitor housekeeping cleanin			
	outside.				and preventative maintenance			
	Gatolac.				issues . The Dietary Manager Dietary consultant will complet			
	O Dumina tha I	Full Kitchen Conitation			Nutrition Services "Quick	l e a		
	_	Full Kitchen Sanitation			Rounds" audit that includes the	e		
		12 at 11:06 a.m., the			kitchen cleaning schedule dail			
	following was	observed:			5 days a week for 3 months ar	-		
					then weekly for 3 months. The	Э		
	A. The pipes b	pehind the stove were			ED will complete a Nutrition			
		ty. There was also a			Services "Quick Round" audit			
		ation of food debris and			weekly for 3 months, then			
	_	ne floor behind the			monthly for 3 months. All findi	-		
	stove and the l				will be addressed and correcte			
	Slove and life i	arge skillet.			immediately and then, All findi			
					will be reported in the monthly			
	I B. The wall tile	e behind the stove and	1		meeting and the PI commitee	vvIII	ĺ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
155218		B. WING 10/23/2012				
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	C		2300 G	REAT LAKES DR	
KINDRE	O TRANSITIONAL (CARE AND REHABILITATION-D	YER	DYER,	IN 46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ty with dried food			determine if 100% compliance has been achieved or if further	•
	spillage.				monitoring is required.	
	C. The wall tile	e behind the three				
		sink was dirty and				
	•	neavy accumulation of				
	dirt.	iour, accumulation of				
	· · ·					
	D. The white F	PVC pipes located				
	under the 3 co	mpartment sink, under				
	the food prep of	counter, and by the				
		a heavy accumulation				
		e and was dirty.				
		,				
	Interview with t	the Dietary Food				
)/22/12 at 11:40 a.m.,				
	_	the above areas were				
	in need of clea					
		g was observed during				
		ntal Tour on 10/19/12				
		ith the Maintenance				
	Supervisor, the					
	Assistant, the I					
		the Environmental				
	•	i ine Environnieniai				
	Consultant.					
	The South Unit	t				
	A Two of three	hoating units in the				
		e heating units in the				
	South Dining F					
		wall properly and were				
	•	air. Interview with the				
		Supervisor at that time,				
		taff sometimes sat on				
	the units causi	ng them to pull away				

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i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BU	ILDING	00	COMPI	летер / 2012	
		100210	B. WIN		PDDDGG GYWY G-:	10/23	12012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE REAT LAKES DR		
KINDREI	O TRANSITIONAL (CARE AND REHABILITATION-D	YER		N 46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG	regulatory or LSC identifying information) from the wall.			TAG	DEFICIENCE		DATE
	i iioiii tile wall.						
	stained and in replacement. T residing in the C. In Room 15 vanity had 2 or	nd the toilet was need of cleaning or There were 2 residents room. , the bathroom sink ne foot sections of					
	, , ,	. There were 2					
	residents resid	ing in the room.					
	The West Unit						
	Room had num were in need o entertainment of section of lamin	the West Unit Dining nerous cracked tile that f replacement. The center had a 7 foot nate edging that was sidents resided on the					
		ection of laminate ssing on the sink in the					
		ase in the men's ad a 6 foot section that th holes.					
	scuff marks on of bed one. The	1, there were black the floor tile at the foot e wall behind the head marred. The faucet in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
155218		B. WIN			10/23/	2012	
NAME OF F	AN OLUMBER OR GUIDNI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	K		2300 GI	REAT LAKES DR		
		CARE AND REHABILITATION-D	YER		IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCE		DATE
	the bathroom had a green stain. There were 2 residents residing in the room.						
		2, there was an					
		of dust and debris along					
	_	e cove base. There was					
		ind the door in the					
	room. There w	ere 2 residents residing					
	in the room.						
		7, the wall by the closet					
	-	ted with two different					
	•	Two residents resided					
	in the room.						
		0, there were cracked					
		d in the room. 10 tiles					
	were cracked a						
	•	There were 2 residents					
	residing in the	room.					
		2, the wall below the					
	window was m	arred and missing					
	•	r was scuffed with					
	black areas be	tween bed one and					
	bed two. There	e were 2 residents					
	residing in the	room.					
	I. In Room 113, the bathroom floor						
	had a black sta	ain in front of the toilet.					
	There were 2 r	residents residing in the					
	room.	5					
	J. In Room 13	2, the bathroom ceiling					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218 A. BUILDING B. WING		00	COMPLETED 10/23/2012					
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYS			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER DYER, IN 46311						
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	vent had an account of the close and not in the residents residents residents. Interview with the Supervisor and Supervisor at the control of	LSC IDENTIFYING INFORMATION) cumulation of dirt and et door was missing oom. There were 2 ng in the room. he Maintenance the Housekeeping he time of the tour, the above was in need			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			

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